



What can professionals do to support  
mothers whose previous children have been  
removed: An exploratory study

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# **“What can professionals do to support mothers whose previous children have been removed: An exploratory study”**

**Emma Blazey & Emma Persson**

Childrens Workforce Development Council (CWDC)’s Practitioner-Led Research projects are small scale research projects carried out by practitioners who deliver and receive services in the children's workforce. These reports are based in a range of settings across the workforce and can be used to support local workforce development.

The reports were completed between September 2009 and February 2010 and apply a wide range of research methodologies. They are not intended to be longitudinal research reports but they provide a snapshot of the views and opinions of the groups consulted as part of the studies. As these projects were time limited, the evidence base can be used to inform planning but should not be generalised across the wider population.

These reports reflect the views of the practitioners that undertook the research. The views and opinions of the authors should not be taken as representative of CWDC.

A new UK Government took office on 11 May. As a result the content in this report may not reflect current Government policy.

# “What can professionals do to support mothers whose previous children have been removed: An exploratory study”

## **Abstract**

As senior social workers working in an inner London borough's front line child protection service for five to six years we have been struck by the fact that the same families become the subjects of safeguarding concerns time and again, often with similar outcomes for subsequent children, in terms of them being removed into substitute care via care proceedings. We were interested in exploring whether there may be more innovative ways of working with parents to enable more children to successfully remain in their parents care.

There were two stages to this project. Firstly we carried out a brief case audit of the 28 families who children's social care were currently involved with in care proceedings, or subject to pre-intention letters, who had had older siblings removed. From these 28 families we then selected six families to gather information on in more detail and study in more depth. Due to the scale of the research project we decided that choosing a purposive sample would best enable us to complete the research, as well as providing us with useful findings. After undertaking a further case audit of those six families from our computer files, we then undertook a series of interviews with their respective allocated social workers.

The case audit highlighted the multitude of concerns and problems faced by the families, and the complexity of worker effort to meet these needs. From the interviews with social workers, it appears there is a deficit in available resources and services for hard-to reach families with multiple, complex needs. The social workers all felt that children's social care had a role to play in affecting parental change, but that this was made more difficult, given their child protection responsibilities. Their role and focus of work was the needs and protection of the children, which put them into direct conflict sometimes with the needs of the parents. As one social worker highlighted, a key question is “How do you affect change when they (the parents) don't want to talk to you, or hate you?”

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## **Introduction**

As senior social workers working in an inner London borough's front line child protection service for five to six years we have been struck by the fact that the same families become the subjects of safeguarding concerns time and time again, often with similar outcomes for subsequent children. We were interested in exploring whether there might be innovative ways of working with parents to enable more children to successfully remain in their parents' care.

Our service works with: children and families who have a child/children in need of family support, these can include;

- children placed under Section 20 of the Children Act 1989 in foster care;
- children who are the subject of care orders or care proceedings; and
- children who are the subject of multi-agency child protection plans

On average each of the 35 social workers in the service, work with 12 families which amounts to approximately 20 to 25 children per social worker. The total number of families receiving a service from children's social care is approximately 420. This equates to an aggregate figure of around 700 to 815 children with whom the service is working at any one time. The seven team managers stated, that they felt that 80% of all the cases allocated to social workers, were of a 'complex' nature. The complexity is based on the cases being multi-faceted, long term and chronic, and involving hard to reach or non-engaged families. This research project focuses on a small subgroup of the cases/families that the service regularly works with.

The situation in our inner London borough in respect of numbers of families in care proceedings or subject to letters of intention in July 2009 comprised;

- in process of care proceedings with **129** families involving a total of **201** children
- of those **201** children, **43** had already had an older sibling removed
- of the **129** families, **33%** had experienced the loss of an older child
- some children had had up to five previous siblings placed away from their parents

## **Aims of the project**

We are interested in exploring whether there are innovative ways of working with parents to enable more children to successfully remain in their parents care. We hoped to be able to identify some types of interventions which can break this pattern, the complexities of the families with whom we are working, and to understand whether different parental circumstances require different approaches.

We initially planned to conduct interviews with both parents who currently had;

- children subject to care proceedings or letters of intention
- who had had previous children removed and
- social workers allocated to the families

We used a core component to the interview schedules, but tailored them to elicit particular insights from each group.

From the social workers we had hoped to establish:

- the key factors that led to removal of the child from the parent
- why they felt previous interventions had not been sufficient to prevent subsequent removal of younger siblings

From parents we had hoped to learn:

- what they understood about the reasons their older child/children were removed
- how far they felt supported to effect changes to prevent this happening with future children
- what they felt would have helped them and what they felt would have helped with the current situation

However, after meeting with our mentor, who highlighted the implications of time constraints, and ethical considerations in a research project on this scale, we decided to interview only the social workers in the service, and not the parents.

## **Background to the Study**

In order to find out what is currently known about this subject, we started by checking the CWDC website to ensure this issue had not been addressed elsewhere, which it had not. We did a literature search, but again could not find anything directly relating to our research topic. We did find a considerable amount of literature which was relevant to our topic, in particular 'The Pursuit of Permanence, A Study of the English Child Care System' by Sinclair et al. (2007) raised some very interesting points in regards to the various outcomes for children in care depending on when they are first accommodated. For example, children under the age of 11 were very likely to have entered the care system for reasons of abuse or neglect and many came from families where there were problems of domestic violence or the abuse of alcohol or drugs. Young people who had first entered the care system over the age of 11 had on average fewer difficulties at home than those who had come in at a younger age. Many of the children in their sample study had been 'tried at home' but came back into care. Many of those in care had

not yet found a placement that lasted. The authors raised several questions for consideration, such as '*should social workers make fewer attempts at rehabilitation and be willing to remove some children at an earlier stage? Such changes might make it easier to provide alternative families to the abused adolescents (Sinclair et al, p83, 2007)*'.

We have searched for information on websites such as Social Care Institute for Excellence's (SCIE), Research in Practice (RiP) and the National Society for the Prevention of Cruelty to Children (NSPCC). However, although we found much useful information in terms of understanding the context of the discussion, we could not find anything that illuminated our specific research question. We also went through a study of the published bi-annual Serious Case Reviews (DfES 2009) for a broader national understanding of the key issues and learning from such reviews.

In order to set the local context for this research project, we used data made available via in-house training material completed in January 2010. We work in one of the largest inner London boroughs, with a population of 255,000. It has a slightly younger profile than the rest of the UK, and children aged 0-19 make up 24.5 per cent of residents. Nineteen per cent of the population is under the age of 15. There are 40 per cent of residents from black and minority ethnic (BME) backgrounds, and this rises to 72 per cent within the school population. There is a high level of socio-economic deprivation, and the average household income is 6 per cent lower than the London average and in some wards more than 15 per cent lower. Approximately 30 per cent of primary and secondary school children are eligible for free school meals. There are 62,900 children in the borough, out of these 504 are children looked after, 292 children are subject to a care order and 193 are subject to child protection plans. There were 3039 reported incidents of domestic violence and 143 teenagers who became mothers in one year.

The borough we work in has one of the highest reported rates of domestic violence of all London boroughs. As a way to address this, MARAC (Multi-agency Risk Assessment Conference) was introduced last year. The main aim is to increase the safety, health and wellbeing of domestic abuse victims, both adults and children. The MARAC representatives meet to discuss the highest risk victims of domestic abuse, and put an action plan together. The borough we work in also has one of the highest teenage pregnancy rates in London, a study by the Office of National Statistics found that 70 out of every 1,000 15 to 17-year-olds in the borough got pregnant between January 2005 and December 2007.

## **Methodology**

There were two stages to this project. Firstly we carried out a brief case audit of the 28 families currently involved our Inner London Borough in care proceedings, or where parents were subject to pre-Intention letters<sup>1</sup>, who had older siblings removed. The brief case audit covered the basic demographics of the families, including information about the referrals; when the children were removed; the concerns noted for the older children; as well as the current child/children, the interventions and services provided to the parents; and the final recorded outcomes for the children, both previously and currently.

The case audit information then provided us with a profile of the families which helped inform the second stage. From the 28 families we chose six families to gather information on in more detail. Due to the scale of the research project we decided that a purposive sample would be conducive to enable us to complete the research, as well as provide us with useful findings. The six families which we chose reflected the diversity of the families using the service in relation to their ethnicity, number of children, different forms of abuse, and different ages of the children removed to give a broad perspective of the cases with whom we are working with. After doing a further case audit for those six families from our case records we then set up interviews with the six allocated social workers to the children. The research team conducted the interviews jointly because we are seeking both factual and impressionistic data. There were some difficulties in gathering a comprehensive understanding of the cases due to some files having limited background information, as well as a cohesive chronology of events that surrounded the children's care planning.

## **FINDINGS**

From the brief case audits of the 28 families we devised a spreadsheet of data. This data highlighted some significant findings and themes.

### **FAMILIES**

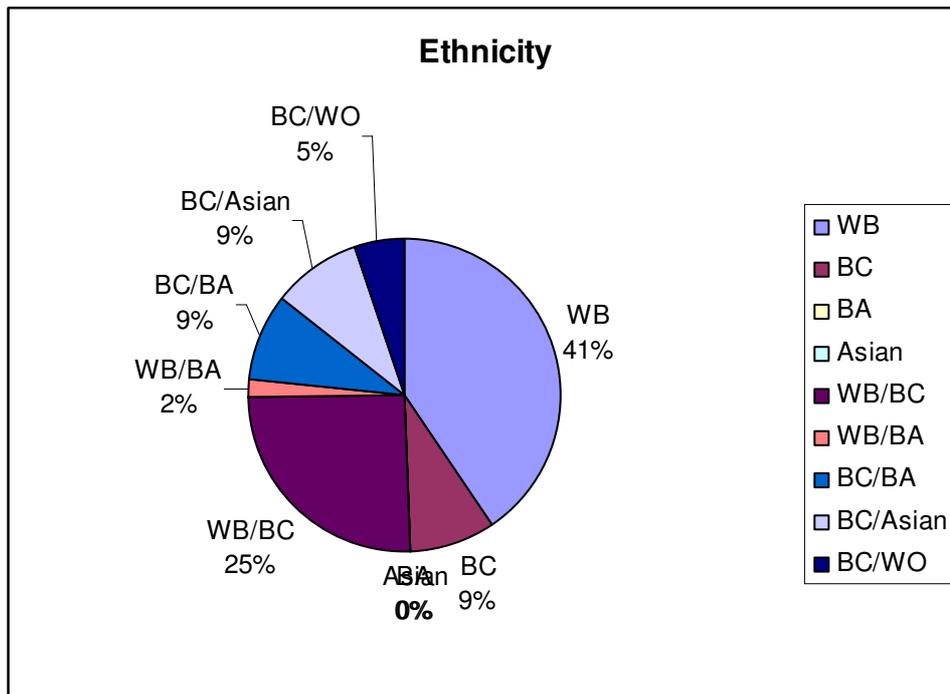
Out of the 28 cases there were 11 cases where no reference to the fathers appeared on file. From the remaining 17 mother/cases, a total of 34 fathers were recorded or referenced on file. The 34 cases where fathers were recorded comprised four cases where there was only one father for the children involved; nine cases where there were two fathers for the children involved; and four cases where there were three fathers involved for the children.

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<sup>1</sup> This refers to a letter sent to parents when the Local Authority is considering issuing care proceedings.

It is not known why the details and information about the fathers are missing but a possible answer to this may be that some of the fathers were not involved in their children’s lives at the time of any care proceedings, or refused to engage with professionals around their parenting capacity.

One child was born in the middle of the care proceedings and was added into the total number of children as they were joined into the proceedings for their older siblings.



## ETHNICITY

*WB= White British, BC = Black Caribbean, BA = Black African, WO = White Other*

The single largest group of children were white British, (n=45), but the largest number of children out of the 111 were of dual heritage (n= 56). That leaves 57 children in total who were born from parents of the same identity and heritage.

In the wider community the black ethnic minority population represents 40% of the total population – highlighting the fact that of the children and families we sampled, black ethnic minorities were over-represented at 59%.

## REFERRALS AND REMOVALS

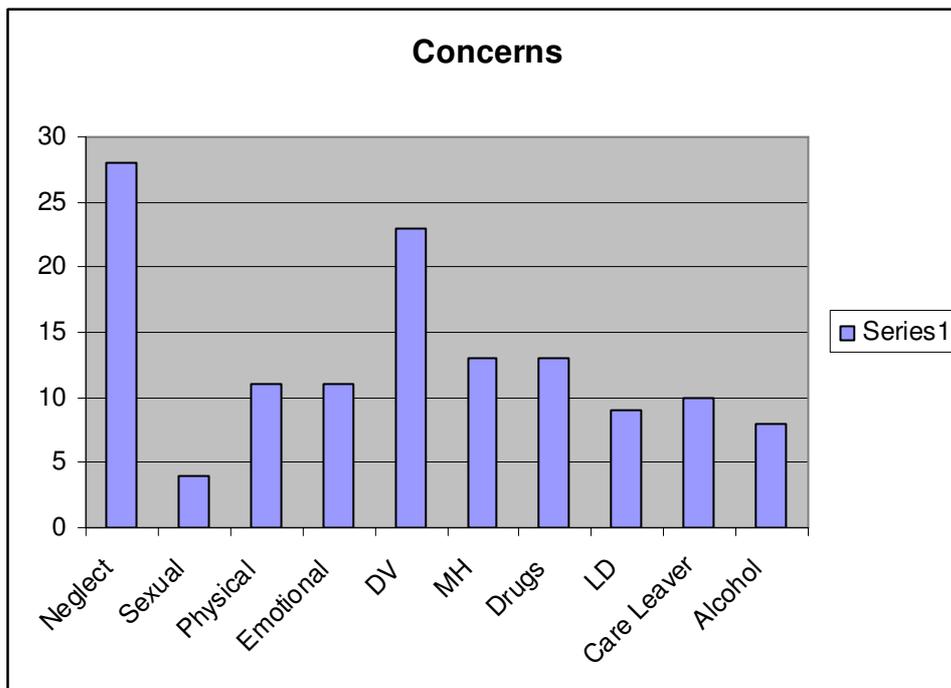
We found from our case audits that the very first referral received in relation to previous children/older siblings was in 1994. This family had therefore experienced children’s social care involvement around their children and parenting for over fifteen years with apparently limited positive change. The opposite end of the spectrum was for a family with a referral relating to

previous children in May 2006 and then for the current child in January 2007 – only five months afterwards.

In terms of the information able to be gathered from our integrated children’s system (ICS) there were 9 cases out of the 28 where we were unable to find any reference to the date of the first referral for the older siblings. There was also one case out of the 28 where there was no reference to the referral; for both the previous referral and for the referral for the current child. In terms of information about the dates of the previous children being removed in 11 cases we could not find any reference of the date of removal, In one case there was no reference of the date of removal of the previous children as well as the current child/children. It should be noted that some of the missing data was related to families that had moved from one local authority to another.

The longest period between the referral received on the previous child/children, relating to concerns around the parenting capacity until the child/children were removed, was ten years. The longest time between the referral received for the current child/children and when they were removed was six years. This highlights that while children’s social care had had enduring concerns around parenting, some children had remained in the care of their parents and carers for a significant period of time before finally being removed.

## CONCERNS RELATING TO PARENTAL CAPACITY

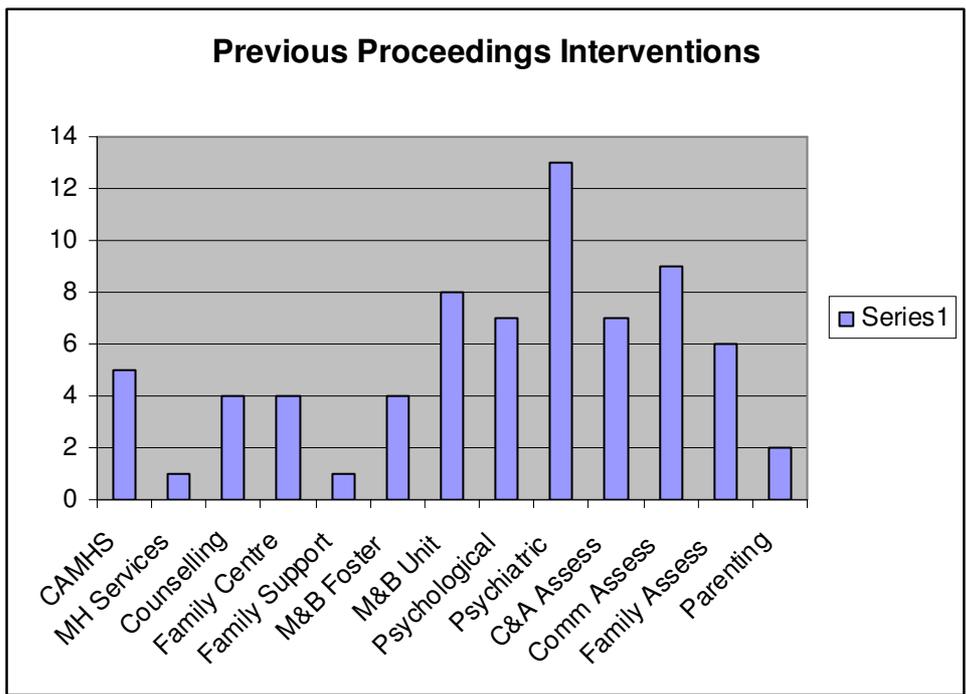


*DV = Domestic Violence. MH = Mental Health. LD = Learning Difficulties/disability. Care Leaver also included Young Parents.*

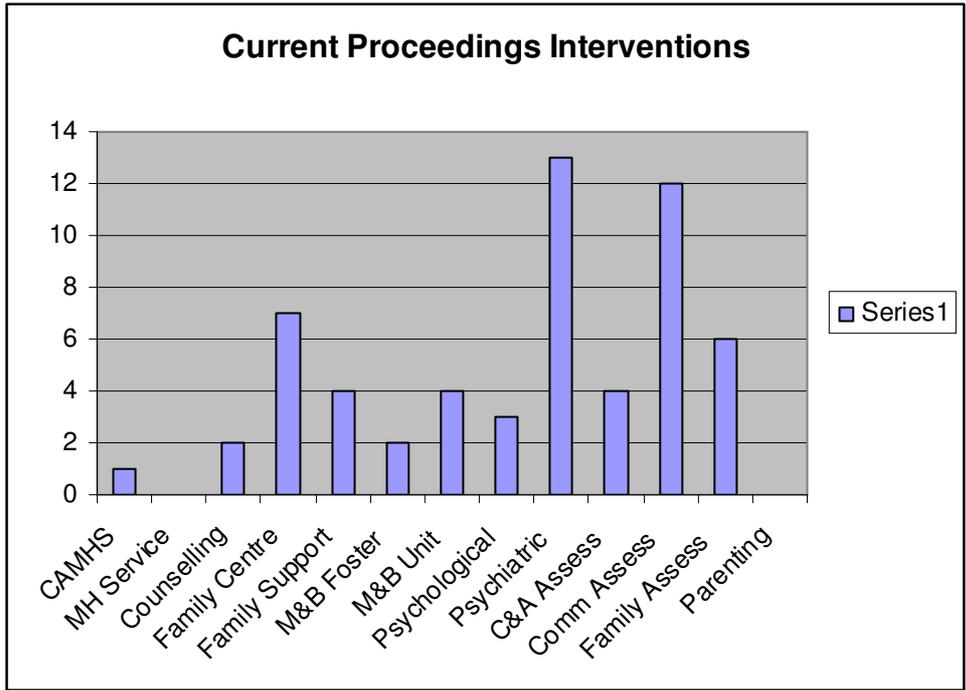
We found that in all 28 cases, *neglect* was noted as one of the concerns around the parenting capacity and the harm the child/children were being exposed to. The next highest area of concern noted was children being exposed to domestic violence, (n= 23).

In 2 cases all four categories of harm were noted as concerns, e.g. neglect, sexual abuse, physical abuse and emotional abuse. On the other end of the scale, the minimum concerns noted were two, for example 2 cases had concerns relating to neglect and parental learning disability, and neglect and physical abuse. All the remaining 26 cases had a complex combination of concerns, impacting on the harm and abuse the children suffered and the issues around the parenting capacity.

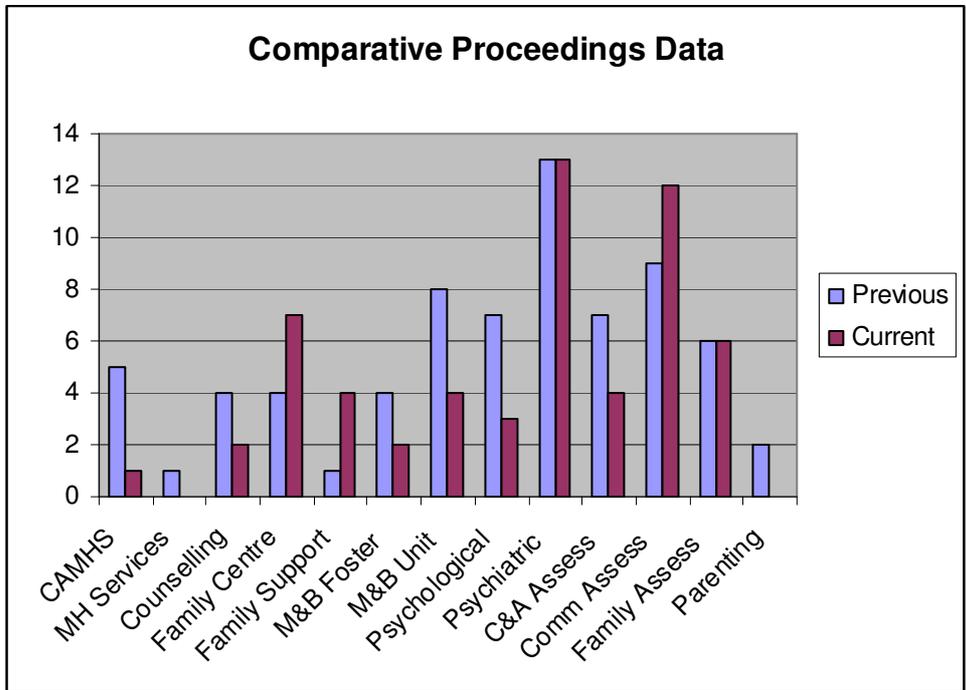
**INTERVENTIONS AND SERVICES PROVIDED RELATING TO THE CARE PROCEEDINGS FOR PREVIOUS CHILDREN REMOVED.**



Number 0-14 relates to the frequency of a service being offered in the proceedings relating to past children removed from the care of their parent. In other words, in 13 of the previous care proceedings a psychiatric assessment was completed. However, family support was only offered in 1 of the previous proceedings.



Number 0-14 relates to the frequency of a service being offered in the current proceedings. For example, in 12 cases a community based parenting assessment was completed.



*CAMHS = Child and Adolescent Mental Health Service. MH Services = Mental Health Services. M&B Foster = Mother and Baby Foster Placement. M&B Unit = Mother/Father and Baby*

*Residential Assessment Unit. C&A Assess = Child and Adolescent Psychiatric Assessment. Comm. Assess = Community Parenting Assessment. Parenting = Parenting Classes.*

We found in both the previous proceedings and the current proceedings that adult psychiatric assessments were undertaken with the same frequency and constituted the *most used intervention*, i.e., in 26 of the 28 cases. The next most frequently used intervention was community parenting assessments, their having been deployed in previous proceedings regarding nine cases; and in current proceedings in 12 cases, i.e. a total of 21 cases out of the 28.

The least used interventions varied within the previous and current proceedings but they covered CAMHS, adult community mental health services, and family support – all being used in 1 out of the 28 cases each time.

The use of family assessments was the same in both previous and current proceedings, at six. We have not analysed the data specifically relating to the assessments undertaken in all care proceedings in our borough, and it is possible that this data would be different. For example, in some of our case studies, the local authority was not prepared to offer a residential assessment where parents had had previous children removed unless there was evidence that the family's circumstances had changed.

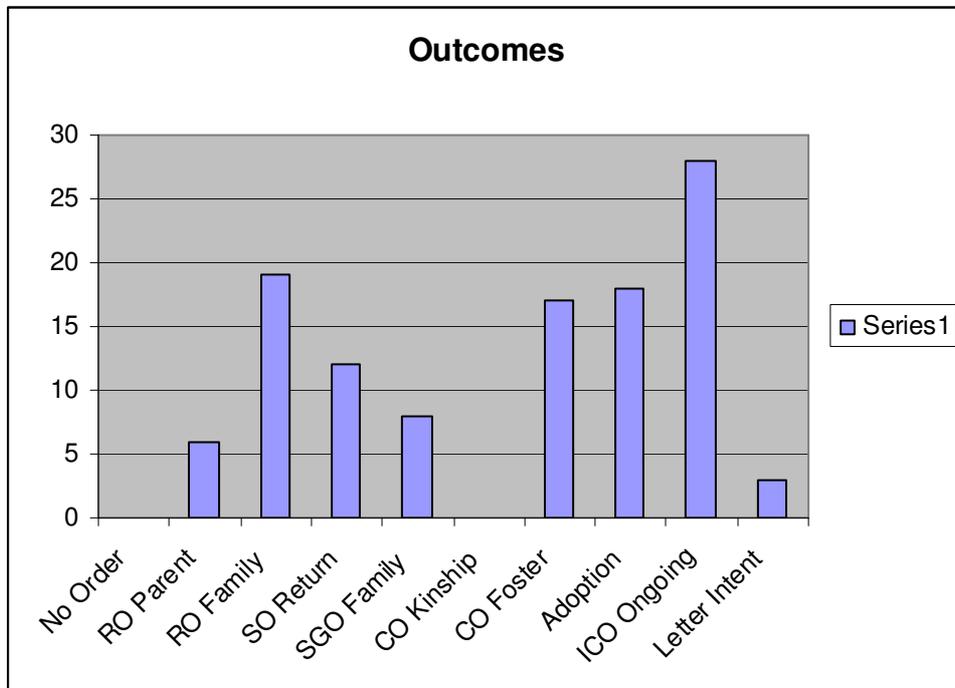
It is important to note that adult psychiatric assessments do not necessarily focus only on assessing *adult mental health*, they also include assessing risks of alcohol and drug misuse, domestic violence and criminal offending behaviour.

The second most common assessment in regard to the families in the case audit was community based parenting assessments, which we found somewhat surprising, given that the outcome for previous children was mostly to be placed permanently with an alternative carer. One reason why community parenting assessments were relatively common, for example they were used in 12 of the current proceedings, this could be fathers having been assessed as a single carer. Another reason could be the Local Authority wanting further information about a mother's parenting capacity, after she had undergone a mother and baby residential assessment, within the previous proceedings. A third reason could be that while the parenting capacity needed to be assessed, the local authority did not want to disrupt the child/children's placement and felt that assessing the parent in the community would provide the necessary information, but not ultimately negatively impact upon the child.

It should be stressed this data has to be read with caution, as some families will have had several assessments, and it is not possible to draw conclusive evidence in regards to the

assessments offered to the families. Also, some parents refused to engage in any assessments.

## OUTCOMES FOR THE CHILDREN IN PAST AND CURRENT PROCEEDINGS



*RO parent = Residence Order to a parent, RO Family = Residence Order to a family member, SO Return = Supervision Order with a parent, SGO Family = Special Guardianship Order to a family member, CO Kinship = Care order to a family member, CO Foster = Care order and Long Term Fostering, ICO Ongoing = Interim Care order and proceedings continuing, Letter Intent = Letter of Intention before care proceedings issued.*

This data relates to the final outcome for children removed in past proceedings and in the current proceedings. We have not broken down the data separately in respect of past/current proceedings. We found that 28 children out of the total 111 were still the subject of interim care orders, with no final decision having been made about their permanent placement. Two of the children were only subject to Letter of Intentions.

We found that out of the 111 children, 18 were permanently placed with their parents, and 28 were permanently placed with extended family members. Thirty five of the total amounts of children were permanently placed outside of their family network, in either long term fostering or adoption.

There were no children, after the care proceedings concluded where 'no order' was seen as the appropriate final decision. In other words, even in cases whereby children returned to the care of their parents this was usually with the provision of a supervision order being granted which ensures that the local authority remains involved for another 12 months to offer befriending, advice and support.

## **PRACTITIONER RESPONSES AND EXPERIENCES**

### **The ongoing tension in professional roles and responsibilities**

All six social workers who we interviewed felt that children's social care have a role in affecting parental change but that this was and is a difficult role to play given their child protection responsibilities. The social workers all felt that their focus of work was the needs and protection of the children, which could well put them into direct conflict sometimes with the needs of the parents. One social worker questioned "*How do you effect change when they don't want to talk to you, or hate you?*" Much of the social workers time was taken up with ICS, meeting their timescales of tasks, and working directly with the children. Unfortunately this left limited time to do proactive one-to-one direct work with parents. One social worker commented that '*We are like project managers, and rely on other agencies for the direct work with the families*'. All of the social workers highlighted that the timescales for children to have final decisions made around their permanency, often conflicted with the timescales for parents to effect the necessary changes in their insight and parenting capacity.

In relation to other agencies taking on the role of working with parenting about effecting change, the social workers all reached the same summary conclusions along the following lines: "we refer out to other services but that adult services either do not have the capacity to do the necessary work, or they have dilemmas about confidentiality, blurring of boundaries, and they cannot force parents to engage."

One of the social workers spoke about the remit of post adoption support and how it is impossible to work with parents before their child is adopted. Another social worker spoke about 'how we should be empowering CAMHS and the Leaving Care Service to work more proactively with parents.' One social worker noted that protection of children is not the focus of the adult services - and those services find it difficult to advocate on behalf of a child as well as the parent/adult. Another thought was that if more work could be done at the family centres, this would be helpful.

All of the social workers spoke about the need for another service being set up that is assertive and provides outreach for parents. The social workers had a number of ideas about the remit of the service which would work with parents around their adult attachments, help them negotiate

their relationships, assist in getting them to go to appointments for therapy and assessments, help them fill the 'voids' in their lives with more positive things, other than drugs, alcohol, violence and pregnancy. The new service would be independent of children's social care but have social workers with knowledge and experience in child protection, care proceedings, therapeutic models, and where the welfare of the child is paramount.

### **Level of Engagement**

The level of parental engagement was an area that all the social workers raised in the interview. One social worker had no issues in working in partnership with the father, who was positively assessed to care for his child, but found by contrast, that the mother lacked insight and an understanding of why she was unable to parent her child. Another social worker did not find the parents to be demanding or difficult to work with, but that they were very hard to engage once a decision was made to reduce the money provided to them by Children's Social Care for reimbursement of travelling costs to contact sessions. Another social worker felt that she was unable to work with a maternal grandfather as she felt he could not be 'reasoned' with and the mother completely disengaged from all services. In one case, the social worker reported that the parents were very difficult to engage, even when the children were subject to child protection plans. Once they became looked after, the mother disengaged even further. On another case, the social worker struggled to work with the parents as they were aggressive, only engaging with the core assessment because it was court ordered, the parents blamed social services for all their problems and the social worker found that the mother "fluctuated from hating me, to talking to me, to hating me". One social worker initially had a good working relationship with the family. However, once they had passed the residential assessment, and were placed in the community, the family disengaged. This social worker was particularly frustrated with the parents' constant lies and commented on 'how difficult it was to know what the truth was with the family.'

All of the social workers commented on the complex, ethically sensitive, and emotive reasons, as to why the mothers in these cases repeatedly fell pregnant. Although contraception, and advice around this area, was seen as important, they all felt it was unlikely that this alone would effect change. Most of the social workers felt that the mothers with whom they were working would fall pregnant again. In one case the mother is already pregnant and due to give birth to her sixth child in a couple of months time. The reasons suggested by the social workers as to why the mothers would get pregnant again were around 'filling the void in their lives,' or related to 'getting into a new relationship with a man.' In most of the cases, the social workers stressed

that the parents often had very difficult childhoods themselves, and several parents were care leavers/young parents.

### **Services Available**

All of the social workers spoke about how children's social care offered social work support throughout their involvement with the family, as well as the number of assessments conducted and offered within the care proceedings. In most of the cases, the mothers' older children and/or children currently in their care had been subject to a child protection plan, and received support by the multi-agency network. In some of the cases, only limited assessments were completed in regards to the parents during the care proceedings. This may be because they disengaged, or because there had been no change since the assessments were completed in previous proceedings. However, some parents were offered a number of assessments, as well as services intended to improve their parenting capacity. It is possible to speculate that in the cases with a high level of assessments, parenting capacity is perceived as more 'borderline' or complex, and professionals judge that with further support and intervention, the parents *may* be able to meet their child's needs.

The social workers were asked to indicate what services and support the parents would benefit from, if there were unlimited resources available. All of the social workers described how the assessments undertaken in the court proceedings recommended that the parents underwent therapeutic intervention. However, the social workers felt that the parents struggled to access such services without support. Given the difficulties of getting parents to engage with therapeutic services, some social workers said that no matter what resources were offered, the parents would find it extremely difficult to make the changes required - "X just wasn't ready for this baby". One social worker suggested that the mother may benefit from a domestic violence awareness and assertiveness course. Another social worker was thinking along the lines of an assessment centre where staff could coach parents with advice via an earpiece, or an Intense mother and baby foster placement where the mother is nurtured just as much as the baby.

### **Allocated Social Worker's Experiences and Feelings**

It was apparent that all of the social workers experienced a range of different emotions in working with these cases. Two of them had difficult working relationships with the maternal grandparents, both of whom had abused and harmed their own children, the parents with whom the social workers were working. One grandparent was a registered schedule one offender, due to the abuse of her grandchildren, who the social worker described as a "horrible, horrible woman" because of the abuse she inflicted on the children. Another social worker "did not like

the grandfather” and she felt that it was not possible to negotiate with him around anything. One social worker spoke about the difficulty in working with a mother with a personality disorder but how she felt that she had a “realistic view” of the mother and was able to not allow the mother to manipulate her emotionally. She did however, note that working with this mother was emotionally draining, and that she felt angry at the mother for still being in contact with the abusive maternal grandmother, and talking about her difficulties and not taking in to account the feelings and needs of her children.

Two of the social workers felt that working with the paternal family members was enjoyable and one described them as “lovely”. In one case a father got the permanent care of his child, and in the other, the child was being placed with the paternal aunt and uncle.

Some of the cases that appeared relatively straightforward at the outset turned out to be much more complex. In one case, there was no father around and the mother had recently had her first child adopted. The social worker said she felt sad in thinking about the mother losing another child, and thought that the mother would get pregnant again in the near future. The child’s father then emerged at the last minute, wanting to be assessed to care for his child, and a positive assessment was undertaken. In another case, a father opened up the possibility of assessments of the paternal family. The social worker commented that *‘it sometimes feels like we are going through the motions – then suddenly a family member appears and is positively assessed and this changes everything’*.

Five of the social workers felt that the information on the local authority files matched their working experiences, but one commented that she initially found the assessment and views of the previous social worker from a neighbouring local authority (who had removed the mother’s previous child) to be ‘very harsh’. However, as the case has progressed, she had come to understand, and agree with the previous assessments. This social worker spoke about feeling very disappointed and angry with the parents, and the delay and hardship this has caused the children.

All the social workers referred to other professionals’ involvement in the cases. One spoke about the police ‘taking the right action in using their powers of police protection to remove the children’, but the worker found that the children’s guardian “*was painful, unhelpful and backstabbing*”. Another social worker also had a very negative experience of working with the children’s guardian. Two social workers described some of the professionals ‘feeling a lot of sympathy for the parents’ but failing to focus on what would be in the children’s best interests, and instead prioritised ‘what the parents needed’. All the social workers spoke about the need

to remain *child centred* and to achieve the best possible outcome for the children they were working with.

The social worker who had the case involving the most changes to the care plan; the most assessments with different /incompatible recommendations; and the most delay, spoke about the difficulty of coping emotionally with working with the parents. She described how difficult it was working with parents who “*would insult me and put me down*”, that she “*got all the shit*”, and that she got to a point in working the case that she “*just got over it, she got too emotionally involved, and she started to take it too personally*”. This social worker felt that working this case had ‘knocked her confidence’ and that she “*hated this case*”. Fortunately, these difficulties were not experienced by all the social workers that we interviewed. However, most of the social workers expressed a sense of frustration at the time it takes to conclude care proceedings (and in one instance the drift in the case and the lack of intervention by previous social workers) and to achieve a sense of permanency for the children. Despite this, the social workers were generally positive whenever a possibility arose that might enable a child to remain either with their birth parents or be placed with their extended family, and supported assessments that may enable that outcome for the children. None of the social workers appeared to have ‘ruled out’ the family just by reading the information on the file, and worked hard to form their own view and assessments of the family. The social workers were committed, and they worked proactively to try and ensure that the child/children were able to be rehabilitated into the care of their parents, or a family member, wherever possible.

We found that the social workers who participated in this research had been qualified between 1-5 years, and all of them had mainly worked in child protection. Two social workers qualified abroad. We believe that this is reflective of child protection work nationally as well as locally. We also found that there was limited or no information about previous proceedings, in terms of services and interventions on ICS. Most of the information about the outcomes from the previous proceedings came from notes made at legal planning meetings. Four out of the six cases within the purposive sample of related families where another local authority had initiated care proceedings before the family moved to our borough.

### **Cost and information for practice**

The average cost of issuing and completing care proceedings for one child is approximately £15,000 to £20,000, for the forty week estimated time scale set out in the Public Law Outline, according to information available from the local authority’s finance record relating to care proceedings undertaken in 2009. This cost is for the court hearings and barristers alone.

The average cost of a placement, including foster and specialist foster placement, and in a residential unit, can be anywhere between £200 to £5,000 per week. The total placement cost (using the guidance from the Public Law Outline of forty weeks for care proceedings cases to be concluded) could be between £8,000 to £20,000 for one child.

On average there could be a mother and baby residential unit parenting assessment, a community based parenting assessment, an adult psychiatrist and/or psychologist assessment, and a child and adolescent psychiatrist assessment of the child/children within one care proceedings case.

On average, the mother and baby residential assessment cost between £30,000 to £50,000 for approximately a twelve week assessment. Community based parenting assessments can cost between £10,000 to £20,000 for an eight to twelve week assessment. An adult psychiatric or psychological assessment costs approximately £4,000 to £5,000 per assessment. The total amount from these assessments could cost between £52,000 to £85,000.

The total for these costs above is between £75,000 to £125,000 for one child for the estimated timescale of forty weeks for care proceedings.

Other financial costs will include contact (contact centre, supervisors, transport for parents, escorts for children), the cost of supportive services being involved with the family and children, financial assistance for parents benefits, financial assistance for housing, transport for parents for court hearings and assessments, all the costs incurred for assessments undertaken on family members (including overseas), section 17 budget funding used for settling in grants for children being permanently placed with family members, and Special Guardianship Order and Residence Order Allowance (paid to family members caring for the child/children until the child/children are sixteen or eighteen years old). The volume of staffing is also significant, e.g. social workers, team managers, service managers, and solicitors.

We have chosen not to break down the above costs as the purpose of this is not to provide a definitive break down of the financial commitment but more to highlight in brief that the cost to the local authority and the community for just one child going through care proceedings is considerable.

### **Suggestions for practice**

Considering the current economic climate and how promoting value for money is always at the forefront of any political agenda, we have looked at some of the current services in the local community that could be strengthened to work further with parents in order to improve their parenting capacity. The current services in the local area which could provide focused work with parents around their parenting skills and helping instill change could include the Family

Nurse Partnership. The Family Nurse Partnership is a new and preventive programme offered to young mothers 19 years old and under having their first baby. The family nurses begin early with the mothers in their pregnancy and can remain in place for the first year of the babies' life. It is an intensive, proactive programme with the aims of improving antenatal health, improving child health and development, and improving the mother's economic self-sufficiency.

Children's social care could utilise the experience and skills of mother and baby foster carers more to empower them to take on a nurturing role with mothers and do more direct work with them. This is because a lot of our young parents have had traumatic childhoods where they have no 'parent figure' caring for them. Some report that the mother and baby foster carers they are placed with are the closest they have come to having a parent. This needs to be clearly and finely balanced with ensuring the safety and protection of the baby in their care.

A stronger link could be built with the local children's centres to assist and support them to do more assertive outreach work with parents. This again would have to be finely balanced with their own roles and responsibilities but also the line of accountability and management (NAO report, 2010)

There is the possibility of looking at the post adoption service to enable them to do more preventative work with parents at an earlier stage and to do more outreach work with them as well. Most of the parents with whom we work may engage for a limited time with support and counselling around losing their child/children to adoption but often their engagement ceases after a short period of time. Therefore, after the child has been adopted, and direct social work involvement has terminated, the parents are without any support if they choose to disengage. Another area that could be strengthened is the leaving care service. The leaving care service will be aware of the high risk category of care leavers that are likely to become parents at an age and stage of their lives where their parenting capacity may be an issue and they could look at how they could be more proactively involved in working intensively with these young people. Within our child protection service there are two therapeutic social workers specifically employed to work with parents around the concerns and risks to their children. Their posts are a recent development but the anecdotal feedback is that they have a significant role in helping effect parental change within families. Unfortunately because there are only two of them, they are spread thinly across the service and they have long waiting lists.

We believe that while there are a number of agencies in the local area that work with the families that we are involved with, we find that they are limited to their own areas of expertise. For example, other agencies sometimes experience a conflict of interest when the needs and safety of children are also involved. They may also struggle with the complexities and multitude

of need, are not able to be as assertive and proactive due to 'parental engagement' and experience ethical dilemmas around confidentiality. The case audit completed has highlighted that the parents are often non-engaging, evasive, move geographical locations frequently, and can be hostile to our involvement in their lives.

Completing this research, doing the background reading, talking with other professionals and agencies has galvanised our belief that in order to effect change in these most hard-to reach parents, a new and separate service may be needed in order to promote and support change. We are however aware that this is only a small-scale research project, and that further research and investigation is required before any consideration would be given to creating a new service in our borough. We also need to work on strengthening the links with the services already in place as outlined above. However, we were thinking that if a new service can be set up, it could be along these lines:

The service would be under the local authority umbrella but independent of children's social care. This would mean that while the council paid the salaries the service would have their own management structure. The work with the parents would be intensive, long term but child centred. It would be made up of qualified social workers, with experience in child protection and court work, an understanding and knowledge of therapeutic models of working with parents, managing challenging behaviour, who have a good understanding of child development, attachment, and the effects of abuse and harm. The social workers would provide an assertive outreach service and would commence working with parents on receipt of referrals, alongside the child's social worker, and continue to work with parents throughout children's social care involvement in an open ended manner.

The social workers would work with the parents around issues highlighted through the court assessments in regards to their parenting capacity, and would for example assist the parents to link in with the appropriate support services, support them in attending appointments, support and have discussions with the parents around contact both before and after the contact session, and help the parents make the links between the concerns held by professionals and their experiences of caring for the child/children, help to empower the parents to make informed and healthy life choices, have discussions around contraception and safe sex, support the parents to understand the final outcomes for their child/children and the changes they need to make for the future.

## **Conclusion**

Our research question was “what can professionals do to support mothers whose previous children have been removed” and we were interested in exploring whether there are more innovative ways of working with parents to enable more children to successfully remain in their parents care. We hoped to identify some types of interventions which could break this pattern, and to highlight the complexities of the families with whom we are working.

From the case audits and interviews with social workers, we found that the issues around the parents’ capacity to care for the children, and the harm that their children had suffered, were complex and multi-layered. The social workers interviewed all felt that children’s social care has a role in effecting parental change, but that this role is often difficult due to their child protection responsibilities. The social workers’ focus of work was the needs and protection of children, which sometimes put them into direct conflict with the needs of the parents. The case audits highlighted that for many of the parents who had had children removed and went on to have subsequent children, the outcome for these children was also permanency away from their parent’s care. It appears that in order to break this pattern, children’s social care needs to consider and review how we work with parents, and work more closely with other agencies to empower them to support parents effect change.

There are a number of services in the community that work in a supportive manner with parents, but these services are often limited in their roles and abilities to work with hard to reach families. For example, therapeutic services were often seen as a key intervention for the parents to affect parental change, but we could not find any cases where the parents had actively engaged in therapy. Nevertheless, it is important and necessary for children’s social care to liaise frequently and in a proactive manner with our partner agencies to bolster and empower them to work effectively with parents. We have highlighted some of the key local agencies which we believe children’s social care could build a stronger relationship with to enable them to actively work with parents regarding their parenting capacity. We are aware that we need to be realistic, and the changes required in some families to successfully parent a child may never be achieved. Nevertheless, it is our view that a more targeted service, aimed specifically at the hard-to-reach families who repeatedly have children removed from their care may provide better results than the current interventions and services offered to families.

If just one child could remain in their parents care because the parents had been enabled to make the necessary changes to their parenting capacity from another service being offered then that should be seen as a significant achievement, a success and ultimately in the best interests of the child/children.

## **References**

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## **APPENDIX**

- I) Case Audit Templates (p24-26)
- II) Consent Form (p27)
- III) Interview Questions (p 28-29)
- IV) Case Summaries (p30-44)

# Case Audit Template

1) Child/ren's name/s:.....

.....  
.....  
.....

2) Date/s of Birth:.....

.....

3) Gender:            Male            Female

4) Ethnicity: .....

5) Religion:.....

6) No of children previously removed:.....

7) No of children we are currently involved with:.....

8) Date of first referral to Children's Social Care:

a) previous child/ren:.....b) current child/ren:.....

9) Date children were removed (or subject to letter of intent?):

a) previous child/ren:.....b) current child/ren:.....

10) Key Concerns for previous child/ren removed:

- a) Neglect,            b) Emotional abuse,            c) Sexual abuse,
- d) Physical abuse,   e) Domestic Violence,            f) Mental Health,
- g) Care Leaver/young parent,    h) Drug Misuse,    i) Alcohol Misuse,
- j) learning disability   k) history of abuse of non biological children

11) Key concerns for current children

- a) Neglect,            b) Emotional abuse,            c) Sexual abuse,

- d) Physical abuse, e) Domestic Violence, f) Mental Health,
- g) Care Leaver/young parent, h) Drug Misuse, i) Alcohol Misuse,
- j) learning disability k) history of abuse of non biological children

12) Key interventions and services offered for previous children:

- a) CAMHS, b) Adult Mental Health Services, c) Counselling, d) Meliot Road Family Centre/Family Centre, e) Outreach services
- f) Intensive Family Support, g) Residential Unit,
- h) Mother & Baby foster placement, i) parenting classes,
- j) Child & Adolescent Psychiatric Assessment
- k) community parenting assessment l) adult psychological/psychiatric assessments m) family assessments

13) Key interventions and services offered for current children:

- a) CAMHS, b) Adult Mental Health Services, c) Counselling, d) Meliot Road Family Centre/Family Centre, e) Outreach services
- f) Intensive Family Support, g) Residential Unit,
- h) Mother & Baby foster placement, i) parenting classes,
- j) Child & Adolescent Psychiatric Assessment
- k) community parenting assessment l) adult psychological/psychiatric assessments m) family assessments

14) Outcomes for past children removed:

- a) Returned home under No Order, b) Returned home under Residence Order, c) Returned home under Supervision Order,
- d) Placed with extended family under Residence Order,
- e) Placed with extended family under Special Guardianship Order,
- f) Placed with family abroad with equivalent orders in UK

g) Care order –Kinship placement, h) Care order -Long-term foster care, i) Adoption      j) ICO  
– ongoing proceedings

15) What services were offered to the family once the Care Proceedings had concluded?

.....

16) Any other issues or comments:

.....

## CONSENT FORM

### Title of Research Project:

“What can professionals do to support mothers whose previous children have been removed: An Exploratory Study”

### Researcher's):

Emma Blazey and Emma Persson

**Please  
initial box**

1. I confirm that I have read and have understood the information sheet dated [28<sup>th</sup> October 2009] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.
4. I agree to take part in the above study.

Participant Name

Date

Signature

Researcher

Date

Signature

Researcher contact details:

## INTERVIEW QUESTIONS

1) **Basic Information:** How long have you been the social worker for the family? How long have you been qualified, experience? SSD Involvement with this family? Basic summary of past involvement? Current care plan for the child/children?

2) What were your initial thoughts and feelings on being allocated to the family and the possible outcomes for the child/children?

*What was the initial care plan?*

*What were your initial thoughts about what the local authority should be doing?*

*Why do you believe this mother keeps having children?*

3) Has the initial plan changed and why?

*Was this our preferred care plan?*

4) Does the information on the files, or from professionals, match your working experience of the family? *Why/why not?*

5) What has it been like to work with this family (knowing the previous concerns and outcomes)?

*Has it changed, e.g. thoughts, feelings etc.*

6) Within these proceedings, what support, services and interventions has the local authority offered?

*Why was this offered? Outcomes? Should additional support have been offered?*

7) What support, services and interventions did the local authority offer in the previous proceedings?

*Why was this offered? Outcomes? Should additional support have been offered?*

8) If resources were not an issue what support and interventions would the parent/s require to enable them to parent these child/children, and/or, future children

*Anything else you want to add in regards to this case?*

-----  
9) What role does children's social care have in effecting change in the parental capacity?

*What other agencies could have a role and how?*

10) What, if anything, can be done differently by children's social care and other agencies to help parents keep these or subsequent children.

11) Any other thoughts or comments?

## **CASE SUMMARIES**

**Please note that all the names have been changed to ensure the confidentiality of the families involved.**

*These summaries relate to the 6 families we gathered further information on and where we went on to interview the allocated social workers.*

### **Case A**

#### **DEMOGRAPHICS**

Case A is a young mother, Miss Walter, who has had two children previously removed from her care permanently by another neighbouring local authority. The father of those children is different to the father of Carol, their child who we are currently working with. Carol is dual heritage with her mother being White British and her father being Black Caribbean.

#### **BACKGROUND**

The first referral about the previous children was received by the neighbouring local authority prior to the oldest child being born. It resulted in a pre birth assessment being conducted. The referral was received in November 2000 and children's social care has been consistently involved with the mother and her children ever since. The older two children were removed under section 20 accommodation three years later by the mother's request due to the domestic violence from their father towards her. They were returned to their mother's care a month later but removed by the local authority in the middle of 2005 after the mother left her children in the care of their maternal grandmother. The maternal grandmother was a schedule one offender for physical abuse against her own child but also allegations of being physical and racially abusive towards the two grandchildren. The children were made subjects of interim care orders the following year, 2006.

The first referral for the current child we are working with in our borough was received prior to her birth. Our borough issued the referral at birth for the baby due to the concerns around the mother's parenting capacity and lack of insight about the concerns over the previous children. The baby was made subject to an interim care order and placed into foster care while mother underwent an updating psychiatric assessment as she had previously been diagnosed with borderline personality disorder.

#### **CARE PLANS**

The concerns relating to the older children were around them suffering from neglect, emotional abuse from being exposed to domestic violence and the maternal grandmother, physical abuse

from the maternal grandmother. Also there were concerns around the mother having borderline personality disorder, being emotionally unstable, self harming, suffering from depression and having numerous suicide attempts. Both mother and father misused illicit drugs and the father misused alcohol.

Mother was exposed to domestic violence as a child, as well as physical and emotional abuse from her parents. She was unable to form a secure attachment with her parents, suffered neglect and instability. Both the mother and her brother were subject to child protection plans and removed into foster care. Care orders were made for them both due to non accidental injuries to the mother's brother. Mother also suffered from physical and sexual abuse from a peer group when she was a teenager. Both her parents misused alcohol.

In relation to the child we are currently working with the key concerns were around mother's history and mental health issues. The father of Carol was not a concern apart from his involvement and relationship with the mother. The physical abuse was still a concern from the maternal grandmother due to mother's lack of insight into the risks that her mother posed to her child. The other concerns noted from the previous children relating to the father were not prominent for the current child.

The care plan was for Carol to be made the subject of an interim care order five days after her birth, to be placed in foster care while her mother undertook the updating psychiatric assessment. Father needed to prove that he was able to separate from the mother before the local authority would consider assessing his parenting capacity. The psychiatric assessment on mother was negative and highlighted that mother was unable to prioritise her child's needs above her own, that she still suffered from borderline personality disorder, that she lacked insight, she was emotionally unstable and that she was unable to make the necessary changes even with therapeutic intervention. An adult psychologist undertook an assessment on father and found that he had average IQ. The father then undertook a community based parenting assessment which was positive and supported the child's permanent placement with him under a supervision order. As parallel planning a viability assessment on a maternal family friend was undertaken, which was negative. The paternal grandmother also put herself forward but pulled out before the assessment commenced.

## **INTERVENTIONS AND SERVICES**

During the first proceedings in the neighbouring local authority the father did not engage nor was he represented. The mother underwent a psychiatric assessment and a community parenting assessment. Both of these assessments were very negative and did not recommend that either of the children were returned to her care. The children underwent a child and

adolescent psychiatric assessment who were very concerned around the harm that the children had suffered while in the care of their mother and father. Mother was offered therapy and parenting support throughout the proceedings as well which she failed to engage appropriately in and was resistant to change. The final outcomes for the older two children were care orders and for them to be placed permanently in long term foster care as they were too damaged to be adopted. The final orders were made in early 2007.

Due to the previous proceedings only finishing fifteen months prior to the current proceedings commencing, the local authority felt that the most important piece of evidence was the updating psychiatric assessment on the mother. Due to the concerns that mother had not changed and the maternal grandmother still posed a risk to the child, Carol was placed straight into foster care. Therefore the only services and interventions offered within these proceedings were around the updating psychiatric assessment on mother, the adult psychological assessment and community assessment on father and then the viability assessment on the family friend. The local authority did not feel that any specific services or interventions would alter the care plan or mother's parenting capacity, and therefore the focus was on supporting the father to care for Carol permanently. The final hearing for Carol was held where a residence order was granted in respect of her father and a supervision order to the local authority and she was placed with him permanently. Carol's mother is to have four times a year direct contact with her.

## **Case B**

### **DEMOGRAPHICS**

Case B is a young mother, aged seventeen, Miss Turner, who has had one child previously removed from her care permanently by our borough. She fell pregnant at the age of fifteen years old and while she was a looked after child herself. She stated that the father of the previous child was her first cousin but his whereabouts were unknown. The father of Matthew is thirty six years old and he is in another relationship. Mathew is of Black Caribbean and Black African origin.

### **BACKGROUND**

The first referral about the previous child was as part of the local authority working relationship with the young mother due to her being in a residential unit and under an interim care order herself. The referral was received from the residential unit in June 2006. Therefore the involvement with this mother and her unborn baby started very early in the pregnancy. A pre-birth assessment was conducted and from all the information known about the parenting capacity of the young mother it was considered necessary to issue at birth. Two local

authority's have been involved with mother and her family since the young mother commenced primary school due to her sexualised behaviours and disclosures of physical abuse from her father. The mother was removed and placed into care, under the interim care order, when she was fourteen years old, and was made subject to a care order three months before the first child was born. The older child and mother were placed in a mother and baby residential unit for a parenting assessment after birth in March 2007 and the baby was made subject to an interim care order. The mother was only able to manage six weeks out of the twelve week assessment before it had to be terminated and the baby removed and placed into foster care separately. The issues were around mother's inability to prioritise the baby's basic needs over her own, lack of supervision, lack of feeding and changing on time, not being able to provide emotional warmth and affection appropriately, and finally nearly suffocating her baby due to falling asleep on her. After the assessments in the care proceedings concluded that the mother was unable to meet the needs of her baby within her timescales the baby was made the subject of a care order and placement order in November 2007 and was permanently placed in an adoptive family.

The first referral for the current child in our borough was received in January 2008 prior to his birth. Issued at birth for the baby due to the concerns around mother's parenting capacity and lack of insight about the concerns over the previous child. The baby was made subject to an interim care order and placed into another mother and baby residential unit while mother underwent an parenting assessment. This is because there was an updating child and adolescent psychiatric assessment completed on mother which stated that she had been able to make some changes and that this needs to be assessed further.

## **CARE PLANS**

The concerns relating to the older child were around them suffering from neglect by mother's failure to provide good enough care, mother being a care leaver, mother misusing cannabis and having been diagnosed with a learning disability and having an IQ of the low average range. No information was held around the father other than what mother told us which was that he was her first cousin, he was eighteen and they wanted to have the child together. Mother was underage and vulnerable.

As a child, mother was exposed to ongoing physical abuse from both her parents, but mainly her father. She exhibited sexualised behaviour at the age of five and when she started primary school (therefore likely to be exhibiting it earlier but that it was not picked up on), being beyond parental control, made numerous rape allegations, absconding from home, stealing and being extremely vulnerable to being victimised and exploited. Her parents failed to engage

appropriately with professionals and were of the belief that their physical chastisement was necessary and they would not stop as it was part of their religious beliefs.

Mother was assessed within her own proceedings as having poor social comprehension and presenting as immature, at risk of significant harm from others, and possibly had been sexually abused which could be continuing. In a psychological assessment they stated that she was a concrete thinker, had poor social judgement, lack of common sense and poor grasp on conventions. The child and adolescent psychiatrist said that mother may have ADHD, an insecure and disorganised attachment style, put herself at risk sexually, and that her parents would not be able to care for her.

In relation to the current child the key concerns were around mother's history and not being able to have made any substantial changes. The Local Authority was still concerned about neglect, that mother had returned to the care of her parents but then left to live in supportive accommodation due to the continuing difficulties in their relationship, illicit drug misuse and continuing to be vulnerable. The father was different for this child and not previously known to the local authority.

The care plan was for Mathew to be made the subject of an interim care order which was three days after his birth, to be placed in a mother and baby residential unit with his mother. The residential parenting assessment failed as mother could not provide good enough care and put her baby at risk of harm. The baby was removed and placed into foster care separate from his mother. DNA established his paternity in the early stages of the care proceedings. A community parenting assessment was undertaken on the father and his new partner which was positive and the plan was for the baby to be permanently placed with his father.

## **INTERVENTIONS AND SERVICES**

During the first proceedings which were only three months apart the mother was offered counselling which she did not engage in. Mother and baby were placed into a residential unit for a parenting assessment which failed and the baby was placed into foster care. Mother also underwent an adult psychological assessment which found her to still have an IQ in the low average range and a psychiatric assessment found mother to not be able to adequately care for her baby, the grandparents were not able to support her and co-operate with professionals and the recommendation was for the baby to be placed into an adoptive family with no direct contact. A family assessment was conducted on the maternal grandparents which stated that they did not engage and were unable to work in partnership, were unable to give the baby emotional stability and they were not able to distinguish between the needs of their daughter and their granddaughter. The viability assessment of the maternal aunt was that she did not

understand the difficulties of the mother and had unrealistic hopes around her sister's abilities to parent. A care order and placement order was granted on the baby and they are permanently placed into an adoptive family.

Due to the previous proceedings only finishing seven months prior to the current proceedings commencing, the local authority felt that the most important piece of evidence was the updating child and adolescent psychiatric assessment on the mother. The psychiatrist recommended that mother had made some changes and therefore a mother and baby residential unit should be offered. This was done so but again the mother failed the assessment before it was due to finish and Mathew was placed into foster care. A community parenting assessment on the father of Mathew was conducted which was positive and recommended Mathew moved into his permanent care. Another family assessment was conducted on the maternal grandparents which continued to be negative. The care proceedings for Mathew are still ongoing but he has been placed with his father whilst being under the interim care order for a short period of monitoring and if this continues to go well then a supervision order will be requested.

Mother was given CAMHS involvement when she was at the mother and baby residential unit but she stopped engaging once she left the unit. She was well supported by the staff at the residential unit as well as being given parenting support twenty four hours a day, seven days a week. Mother did not engage with the child protection social worker or her leaving care social worker.

## **Case C**

### **DEMOGRAPHICS**

Case C is a mother, Miss Harris, who has four children altogether, Brian, Dwayne, Lisa, and Harold. The three older children were removed from her care and then she became pregnant during the care proceedings and the baby then was removed and became joined in the proceedings. Therefore, there were three children removed and one child added to them. The father of the older children is different to the father of the younger two children, but was involved within the care proceedings and the assessments for all the children. The younger two children were White British and the older two are dual heritage with her mother being White British and her father being Black Caribbean.

### **BACKGROUND**

The first referral about the previous children was received in May 2004 for the older two children. The referral was mainly around the domestic violence that the children were exposed to from their father towards their mother. The family were living in a different London borough

where they conducted an initial assessment but closed the case shortly afterwards. The mother finally left the abusive relationship and then commenced a relationship with the father of the two younger children. A referral was received from the hospital in our borough in 2007 after the new partner was witnessed handling the older children roughly whilst at an ante-natal appointment for the third child, who was then unborn. Two months after the third child was born the police were called to the family home after a disturbance and the three children were removed from their parents care under police protection. Three days later an interim care order was granted in respect of these three children in September 2007 and they remained in foster care together. The first referral for the current, and forth child, was received in August 2008 a month before the forth child was born. Due to the older three children being subject of interim care orders and care proceedings ongoing the forth child was joined into the proceedings and the care plans then reflected this change. The local authority issued at birth for the baby and once it was discharged from hospital it joined mother and his siblings at their assessment unit.

## **CARE PLANS**

The concerns relating to the older two children were around them suffering from emotional harm from being exposed to domestic violence, neglect, physical harm/abuse, mother suffering from depression, and mother's alcohol and drug misuse. Mother eventually managed to leave that relationship and commenced a relationship with the father of the younger two children.

The concerns about the younger two children were around neglect, emotional abuse of domestic violence, physical harm/abuse from mother, mother's alcohol and drug misuse and the father of the younger two children being a care leaver.

The parents presented as a couple initially but then separated in order for the mother to possibly get the children returned to her care within the care proceedings. Unfortunately due to the parents not separating in a 'natural' way they continued to see each other at times, hence the forth child being born, and the domestic violence continued.

The care plan for these four children changed significantly throughout social care's involvement and there was a lot of delay that was caused by the changes. The first stage of the care plan was to assess the parents together as they were a couple. The community parenting assessment was completed whilst the three children remained in foster care. The assessment centre recommended that the parents could not meet the needs of the three children and that an adoptive placement would be their best outcome. It was at this stage that the parents separated at this point, under the advice from the Guardian, as the mother could have a chance to care for the children alone.

Soon after the parents separated, information came out that the mother was pregnant with the father's second child, the fourth child. The local authority had been planning for the older two children to be permanently placed in a long term foster placement and the younger third child to be adopted prior to this information but then the guardian supported the mother going into a residential unit with all four children to be assessed by herself. The care plan was then for mother to move into the residential unit with the youngest child, the third child, to start the assessment and if it went well then the new born baby would be placed with them after it was born. This happened and eventually the older two children were placed along with their two younger siblings and their mother. To support the care plan there was a child and adolescent psychiatric assessment completed on the children and this recommended the four children to be placed with mother in a structured manner into the residential unit.

The outcome of the residential unit was that the mother could parent two of her four children but not all four. Unfortunately they did not specify which two children it would be better for. The local authority's care plan then was for the younger two children to be adopted and for the two older children to be rehabilitated into the care of their mother permanently. The guardian did not agree with splitting the children (even though this was the recommendation from the residential unit). It was finally agreed between the parties that mother would move back into the community with her four children having a community parenting assessment from the residential unit and with assertive outreach support. The community assessment went well and the local authority was going to support a supervision order in respect of the four children and for them to remain with their mother permanently in the community.

On the day of the final hearing a referral was received from the neighbours informing that there was a domestic dispute between the mother and the father of the younger two children. The final hearing was adjourned, a legal planning meeting was held and the local authority changed their care plan to all the children being removed from their mother's care, and that the older two would be permanently placed in long term foster placements and the younger two children were to be adopted. This plan was not accepted by the other parties or the court, and the court made interim supervision orders instead as the local authority refused to continue to want to share parental responsibility with the mother with the children at home.

Mother moved out of our borough with the four children to women refuges but the locations changed a number of times due to the mother providing the details to her ex partner so he knew where she was. Mother is currently living in another part of the country but the local authority in which she is residing in with the children have refused to accept final supervision orders so the care proceedings are continuing until this issue can be rectified.

## **INTERVENTIONS AND SERVICES**

As there was one set of proceedings but involving three children, and then the baby being joined the assessments were offered consecutively.

Within the time that the family was known to our borough they were offered CAMHS involvement, support for mother to engage with the adult community mental health team for her depression. The family were also offered intensive family support from the outreach work as well as another agency that works with parents with young children. The mother was also offered and referred to counselling for herself and was referred to an alcohol recovery project. Referrals were also made for mother to attend domestic violence support groups, financial support for the family to move out of the borough, and financial support for after school clubs and a nursery for the younger children.

The mother and father were assessed in the community by a family centre which recommended that neither parent could safely parent the children and recommended that children should be placed in adoptive placements. Even though this was the recommendation from the family centre this was contested and further assessments were undertaken. There was an adult psychiatric assessment conducted on the mother mainly focusing on her alcohol and drug misuse and the domestic violence within her relationships with the fathers. Then there was the residential parenting unit assessment of the mother with the four children which ended up with the recommendation that mother could keep two of her children but not able to care for all four. Again, the recommendation was not accepted by the parties and the mother returned to the community with all four children whilst having a community based assessment and intensive outreach support.

Alongside these assessments of the mother there was a viability assessment of the older two children's father which was negative. The older two children's paternal uncle underwent a viability assessment which was also negative. Then the younger two children's father underwent a viability assessment (after he separated from the children's mother) which was positive and recommended a full parenting assessment from an independent social worker. This was completed but the recommendation was that the younger children's father was unable to care for his two children adequately.

## **CASE SUMMARY D**

### **DEMOGRAPHICS**

Case D is a mother of six children. Her oldest two children were placed in long-term foster care, the subsequent three children have been adopted and her youngest child, Anna, is subject to ongoing care proceedings. The family is of white British origin. Anna has been placed with her extended paternal family, and the plan is for them to adopt her. Anna is her father's first and only child. The mother's oldest children were subject to child protection plans and were later removed due to neglect. Her next two children were removed shortly after birth. The mother then moved to another local authority where she had her fifth child. This local authority tried to give the mother a chance to parent her daughter, and she had a residential and community based parenting assessment which was not successful. The parents then moved to our borough, who removed Anna from the care of her mother at birth. Anna suffers from foetal alcohol syndrome.

### **BACKGROUND HISTORY**

There have been long standing concerns by three local authorities due to the mother's chaotic lifestyle, neglect and alcohol abuse. The first referral regarding mother's oldest child dates back to May 2005. Anna is the first child of Mr Smith, and the concerns around him centre around his long history of alcohol misuse, possible use of drugs and a violent history.

Ms Brown had a difficult childhood and was in care from the age of 2 years due to physical abuse. Ms Brown's care history was difficult, and she had several placements. She became involved in a relationship with Mr X, which featured domestic violence. Ms Brown fell pregnant with her first child when she was young, and concerns arose that she had neglected her daughter. Kelly and Kim were removed in 1998 and had been subject to a child protection plan for 2 years prior to this. Ms Brown was in a new relationship with Mr Z, which also featured domestic violence. Mr Z is the father of Kim, Ben and Mark, and the concerns continued to centre around the parents' chaotic lifestyle, domestic violence and alcohol misuse. Ms Brown is well known to the police, and has 48 convictions and 79 offences, mainly for theft. Ms Brown met Mr Smith in 2001, and they have remained in a relationship since then although she has had children with Mr Z whilst in a relationship with Mr Smith. This relationship was also featured with domestic violence.

### **CARE PLAN**

The local authority issued care proceedings upon the birth of Anna, and she was placed in foster care. Following an updating psychiatric assessment of mother and an initial psychiatric assessment of the father, both parents were ruled out as carers for Anna. They appeared to

accept this, and have not put themselves forward as carers. It appeared likely that Anna would be adopted as well. However, a paternal aunt and her husband came forward and were positively assessed for a special guardianship order. The child's guardian was of the view that Anna should be placed with her aunt, but that this should be an adoptive placement. This created some difficulties and delay, as the couple had to be assessed again but as adopters and the couple had to attend adoption preparation groups. Anna is suffering from foetal alcohol syndrome, and her difficulties appear to increase as she grows and develops. The financial aspect of the case, e.g. whether an adoption allowance should be paid to the aunt and uncle, still needs to be resolved.

### **INTERVENTIONS & ASSESSMENTS**

Ms Brown has been drinking since at least 1996, and Mr Smith has a long history of alcohol misuse as well. Both parents have admitted to using drugs, and the father admitted to being a current user of crack cocaine. Ms Smith denies drinking during her pregnancy, however, Anna has been diagnosed with foetal alcohol syndrome. Mother was offered a place at an alcohol rehabilitation centre in 2008, but did not follow through. The father has a long history of convictions, e.g. burglary, possession of illegal substances, assault and malicious wounding. It is not clear what assessments and interventions that were offered in respect of the mother's first two children, and apart from updating psychiatric assessments, few assessments were undertaken in respect of her next two children (who were placed for adoption). However, a neighbouring local authority appeared to give the mother a 'fresh start' with her fifth child, and she went into a residential unit and was assessed and supported by attending sessions at a local family centre. This ultimately failed due to mother's chaotic lifestyle and drug and alcohol misuse.

Our borough was not prepared to offer a residential parenting assessment due to the long-standing concerns and no positive change. Following a negative psychiatric assessment in regards to both mother and father, they were ruled out as carers for the baby. A positive viability assessment and kinship assessment was completed in regards to the paternal aunt and uncle.

### **CASE SUMMARY E:**

#### **DEMOGRAPHICS**

Case E is a white British mother who has had five children. Three of the children have been permanently removed from her care, and we are currently in care proceedings with her youngest two children. The oldest child, aged 8, is placed in long term foster care and the next

two children, aged six and four, are adopted. Her fourth child, Charlie, was subject to care proceedings by a neighbouring local authority, and his proceedings were later joined together with the mother's youngest child, Mark. The mother fell pregnant with Mark whilst there were ongoing care proceedings relating to Charlie. Charlie and Mark have the same father. The concerns centre around chronic neglect and domestic violence.

## **BACKGROUND HISTORY**

The mother has led a very unstable life, she has moved to 26 different addresses due to failure to pay her rent, antisocial behaviour and fleeing domestic violence. The children's father also had a very unstable childhood. His mother had alcohol problems, thus he was placed in care due to suffering neglect. He has a long criminal history which includes arson and burglary. There are concerns that he physically abused children from a previous relationship. The mother was in a very violent relationship with the father of her two eldest children, Mia and Sarah. She also had a still birth, caused by physical abuse, which left her very traumatised. The first two children have the same father. The mother met the father of her third child, Rachel, in 2006 and soon found out that he did not have any interest in her older two children, and wanted her to give them to her mother to care for. The first referral for this family was received in February 2002, and Mia and Sarah (once born) were subject to Child Protection Plans due to neglect between 2004 - 2006. An interim care order was granted in 2006, but the children remained at home. A residential assessment unit completed a community based parenting assessment and a psychological assessment of the mother was also undertaken. They found that the local authority's concerns were founded and that the mother falls into the borderline range of ability and experience and to be operating at a level commensurate with semi-independent living. The mother was also assessed as having some schizoid and avoidant personality traits, and she has a history of non engagement with services and professionals. The concerns centred around long-term neglect and the children witnessing domestic violence and the outcome was for two of the children to be adopted and one placed in long-term foster care in May 2007.

## **CARE PLAN**

Mother became pregnant with Charlie whilst the care proceedings in regards to her older children were ongoing, and gave birth to him in December 07. The local authority's plan was to remove him at birth due to previous concerns. However due to miscommunication, the mother was able to return home with Charlie from the hospital. A community parenting assessment was undertaken. The final report in May 2008 concluded that the mother would not be able to provide a secure and stable home environment for Charlie to grow up in and that there is a considerable risk of him suffering significant harm should he remain in the care of his parents.

The report recommended that Charlie should be removed from his parent's care and permanent alternative carers to be sought. Charlie was placed in foster care. Mother became pregnant with Mark whilst the care proceedings were ongoing, and the parents moved to our borough in August 08. Mark was born in October 08, and was removed at birth and placed in foster care and care proceedings were initiated. The parents applied for, and won a contested hearing in court, the right to be placed together with both Charlie and Mark at a residential unit for a three month assessment. The care proceedings by the two boroughs were consolidated. The parents passed this assessment, and it was agreed for a community based parenting assessment to be undertaken with the parents living with the children at the family home. However, soon after the family returned home, the parents started to disengage from professionals. Housing was an ongoing issue, and the parents started to lie to professionals about the reasons for missing appointments. There have been problems with benefits. Children's social care strongly advised the family against going into private rented accommodation, and especially the actual property they moved into, as the rent was £90 per month over housing benefit rates. The parents said that they had sorted their housing benefit, but their landlord was trying to evict them. They did get about £5000 backdated benefits, which they spent on a huge flat-screen television. They frequently requested financial support from the local authority and became abusive when this was refused. The local authority was paying for Charlie to go to nursery four and a half days a week. Mother was supposed to take Mark to an early years activity once a week, but although the parents say that they have done this, there has been no record of this when this has been checked. Similarly, mother said she is taking the children for health appointments, and she has not been. The parents were avoiding the agency support worker and were not letting the social worker in for visits. The children's presentation had deteriorated. Father is dangerously obese and does not undertake practical tasks within the home or for the children. Sometimes the children are strapped into their pushchairs when they are at home. The local authority's concern is that the old patterns of behaviour have immediately re-emerged now that the family are in the community. Another community based assessment will be completed in order to determine the long-term care plan for the children. The mother is pregnant again, and is due to give birth in May 2010.

## **INTERVENTIONS & SERVICES**

The mother has been through a community based parenting assessment in the care proceedings relating to her oldest three children. She was also assessed by a psychologist who concluded that mother falls into the borderline range of ability and experience and to be operating at a level commensurate with semi-independent living. The mother was also

assessed as having some schizoid and avoidant personality traits, and she has a history of non engagement with services and professionals. Another community based parenting assessment was undertaken in regards to Charlie, which concluded that the parents were unable to provide good enough care for him. Charlie was subsequently removed from their care. However, following a successful application in court, the parents were granted the chance to parent both children at a residential unit. They passed this assessment, and were placed in the community with support services in place. However, the care of the children deteriorated, and mother is now pregnant again. It is proposed that another community based parenting assessment be completed which will help determine the long-term care plan.

## **CASE SUMMARY F**

### **DEMOGRAPHICS**

This case is a mother of three children, her oldest child is adopted and there have been ongoing care proceedings in respect of her subsequent two children. Mother is White British/Asian and the father of the youngest two children is White British. Mothers first child, Oscar, was subject to a child protection plan in another local authority due to concerns around neglect, drug and alcohol misuse and domestic violence. Care proceedings were initiated and Oscar was placed in foster care in 2002 and was later adopted. Mother fell pregnant during the care proceedings, and moved into our borough in 2002. She has since had another child, whilst living in this borough. The children we are working with are now aged three and six.

### **BACKGROUND HISTORY**

The family has a lengthy history of involvement with children's social care. Ms Reid first came to the attention of children's social care in another local authority in 2002 when concerns were raised in relation to the welfare of her first child Oscar. These concerns were primarily due to neglect and evidence that Ms Reid and her partner were not able to prioritise Oscar's needs or keep him safe. There was concern that Kieran was cared for by inappropriate adults despite advice from professionals and that he was put at risk by adults using substances in his presence. There was concern expressed about the home environment and that it was unhygienic and caused a risk to Kieran's safety. He was made subject to a child protection plan in 2002, and was removed in July 2002 under police protection and placed in foster care. Oscar was subsequently placed for adoption outside his birth family in 2003. Ms Reid and her new partner Mr Edwards, father of Kevin, moved to our borough in August 2002 and Kevin in April 2003. Due to concerns in regards to Ms Reid's parenting of Oscar, Kevin was made subject to a child protection plan in our borough in April 2003 under the category of neglect. A legal

planning meeting was held but the decision was made not to issue care proceedings at that point. Kevin's sister Mary was born in 2006, and her name was added on the child protection register at birth. Throughout the period of the children being subject to child protection plans, Ms Reid was offered support from children's social care and the family centre to improve her parenting skills and reduce the risk to Kevin and Mary. Ms Reid did slowly make some positive changes however and Kevin ceased to be subject to a child protection plan in December 2006 and Mary also ceased to be subject to a child protection plan in September 2007. From September 2008 concerns again began to increase in relation to the care Ms Reid was providing to the children. Kevin's school attendance had fallen below 50% and Mary was not registered at any nursery or playgroup. Ms Reid did not engage with the social worker or health visitor and the home environment had deteriorated significantly. Due to concerns around neglect, a S47 Investigation was undertaken in December 2008. Ms Reid did not engage with this and informed that she was in the process of leaving the area as she was fleeing domestic violence from the children's father. In January 2009, children's social care were informed that Ms Reid and the children were living in a hostel in South East England. The two children were made subject to a child protection plan under the category of neglect in that borough. Concerns were raised that Ms Reid was in regular contact with the children's father, and that she was not honest with refuge staff. Ms Reid and the children then returned to our borough. In February 2009, Kevin's school informed that his mother had smelled strongly of alcohol when she collected him from school. In February 2009, Kevin also made an allegation that he had been inappropriately touched by a man. This man was known to the police and was arrested. Police requested that Kevin be brought to the police station for an achieving best evidence interview. The social worker took him to the police station. The police informed me that when they met with Ms Reid at the home address that morning to discuss the allegations, there were two males present at the family home drinking alcohol. The children were also both present. Kevin disclosed that he had been "hurt" by a man and he was "scared". Due to the disclosures made by Charlie and concerns that Ms Reid was not able to protect the children from inappropriate adults, and the adults who had been in the house that morning drinking, the police removed the children from Ms Reid under police protection and placed them with a local authority foster carer. There were no other family members available to place the children with who had been assessed as safe and appropriate to care for the children. An interim care order was granted in respect of both children in February 2009.

The concerns that arose in regards to Kevin and Mary are very similar to those which led to Oscar being adopted. The mother shows no understanding of the children's basic needs. The

family had five moves in the past year due to non payment of rent, voluntary giving up tenancy to live with friends, then being moved on from that family. There were significant concerns about the home environment, which was completely unfurnished except for mother's bed. School said that Kevin wears the same dirty clothes all week (uniform). He turned up for school in clothes the teacher described as rotting and turned up in trousers much too big for him, that had to be tied up with string. The children often have filthy hands, as if they have not washed for days. Mother also has poor hygiene. Mother says she has been prescribed anti-depressants after Oscar was adopted. Mary's two year check was outstanding and she had outstanding immunisations. Mother has only attended 3 out of the 12 appointments with the health visitor. There were no toys in the house except for one toy pram and some broken cars. Health visitor has got Mary nursery places, but mother has not taken them up.

### **CARE PLAN**

The initial care plan was for mother to be offered a residential assessment together with the children. However, they had settled very well with the foster carer and it was felt to be in their best interest to remain with the carer whilst further assessment was completed rather than be placed with their mother in a residential setting. The children remained living with their foster carer, and the assessments completed in respect of Ms Reid and the children's father were negative. The final care plan for the children was adoption, and a care order and placement order in respect of both children was granted in January 2010.

### **ASSESSMENTS & INTERVENTIONS**

It is unclear what assessments were undertaken in respect of Oscar by the other local authority. However, the concerns raised were very similar to those raised in regards to Kevin and Mary, e.g. neglect, domestic violence, and drug misuse. It is believed that a psychiatric assessment was offered in respect of Ms Reid and her ex-partner, but neither one engaged. Mother then started a new relationship and she and her partner moved to our borough in 2002 whilst the care proceedings in regards to Oscar were ongoing. She failed to keep in contact with Oscar and did not engage with the social worker from that borough. Due to the concerns raised in regards to her care of Oscar, a legal planning meeting was held by our borough in 2002 in regards to mother's unborn baby (Kevin). It was decided not to issue care proceedings at birth, but to work with the parents and make the baby subject to a child protection plan. Kevin was subject to a child protection plan between 2002 - 2006, and his sister between 2002 - 2007. Ms Reid was offered parenting support by attending the family centre weekly, but her attendance was sporadic. She was also offered intensive social work support by way of home visits. The children were worked with as children in need until 2008, when the concerns around the care

provided again increased. They were eventually placed in foster care, and a psychiatric assessment was completed in regards to mother. A child and adolescent psychiatric assessment was also completed. The child and adolescent psychiatric assessment recommend.

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