DOCTOR OF SOCIAL WORK

“Nobody wants to remove a baby... That’s the crux of it”

Social Workers’ Experiences of Undertaking Pre-Birth Assessments

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II. List of Illustrations and Tables

III. List of acronyms

ASYE	Assessed and Supported Year in Education
BIC	Born into Care
CA	Core Assessment
CAFCASS	Children and Family Court Advisory and Support Service
CPD	Continuing Professional Development
DfE	Department for Education
FDAC	Family Drug and Alcohol Court
IA	Initial Assessment
ICO	Interim Care Order
ICPC	Initial Child Protection Conference
IRO	Independent Reviewing Officer
LA	Local Authority
LARC	Long-acting Reversible Contraception
LSCB	Local Safeguarding Children Board
NFJO	Nuffield Family Justice Observatory
NHS	National Health Service
NQSW	Newly Qualified Social Worker
NSPCC	National Society for the Prevention of Cruelty to Children
PLO	Public Law Outline
PSW	Principle Social Worker
RCPC	Review Child Protection Conference
SCR	Serious Case Review
TA	Thematic Analysis
WFD	Workforce Development
WTSC	Working Together to Safeguard Children

IV. Dedication

For my Dad, who encouraged me to reach for the stars.

V. Acknowledgements

I would like to thank a number of people for their support, suggestions, encouragement, and guidance over the last four years.

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VI. Signed Declaration

I declare that I am the author of this thesis, that all references cited have been consulted by the author, that the work of which the thesis is a record has been carried out by the author, and that the work has not previously been accepted for a higher degree.

Signed: C. Bleasby

Date: 12/12/2022

VII. Summary of the Thesis

Pre-birth assessment is an area of children and families social work which has received very little attention in terms of research and practice guidance. There is evidence across western countries that statutory intervention to protect newborn children has increased significantly over the last decade, with growing concerns that research and guidance to support practice have not increased at a similar rate. A gap in current research is the experience of social workers undertaking the work, with no studies focused solely on this area to date. This qualitative study used semi-structured interviews to explore the experiences of social workers undertaking pre-birth assessments within one region of England. The findings have situated pre-birth assessment as intrinsically complex, fundamentally emotional, and highly uncertain; where the consequences for the children, families and social workers can be catastrophic, and yet appear to be broadly unrecognised. Pre-birth social work is placed as a distinct area of practice where there are several unique challenges to assessment and decision making, with the child at the centre of the assessment remaining invisible throughout the work. Overwhelmingly, social workers reported feeling unprepared for the work which has significant moral and ethical implications due to the potential impact of the decisions being made. The findings highlight the need for urgent developments in the way pre-birth social work practice is approached and several recommendations for practice, policy, education and research are made.

1. Introduction

1.1. Introduction

Pre-birth assessment is one of the most challenging and complex areas of child and family social work. It is fraught with legal and ethical tensions and yet there is very little guidance or research available to support social workers with this role. Pre-birth assessment work has grown significantly in recent decades, but little is known as to why this is. The experiences of those involved in pre-birth assessments are almost entirely absent from the literature, from both families' and professionals' perspectives. Social workers take the professional lead on undertaking pre-birth assessments and yet no studies to date have explored the experiences of social workers who undertake this work in depth. This study represents the first piece of research that has considered the experiences of social workers undertaking pre-birth assessments holistically, considering all aspects of the work rather than focusing only on instances of infant removal.

This introductory chapter sets the scene of this thesis. It starts by providing an overview of what pre-birth assessment is and where it sits in the wider context of child and family social work, although this is explored in much more depth in the literature review (see Chapter 3). My motivations to study pre-birth practice and my research journey are then explored, making links to one family that I worked with and how the pre-birth assessment work I did with them shaped the course of my career. This then leads to the formation of the research question the thesis seeks to answer, before the structure of the thesis is outlined.

1.2. Setting the scene: pre-birth assessment in social work

This thesis explores one very specific aspect of child and family social work practice, assessments undertaken with families before the child is born. Pre-birth assessment in social work involves social workers and other professionals assessing the needs of and risks for babies before birth to make decision about their care once they are born (Critchley, 2018b). They are undertaken when there are concerns about the parents' capacity to care for the child after birth (Hodson and Deery, 2014). Pre-birth assessments are arguably one of the most difficult tasks that social workers might undertake (Barlow et al., 2019; Lushey et al., 2017). This is in part due to their subjectivity and indeterminacy, with no child to observe, interview or examine (Hart, 2001) and social workers having to assess and predict future parenting based on past and current parental behaviour and risk factors (Juhasz, 2020). There is evidence from research that uses care proceedings data that statutory intervention shortly after birth is increasing in the UK (Broadhurst et al., 2018) and in other western countries (Harrison and O'Callaghan 2014, Harrison et al., 2020; Hestbæk et al., 2020). Yet pre-birth work remains an area which is lacking in guidance (Broadhurst et al., 2018; Lushey, 2017) and academic research (Critchley, 2020a; Hart, 2002; Hodson, 2011; Mason et al., 2019).

Pre-birth assessments first emerged in social work practice in the 1970s (Fairburn and Tredinnick, 1980). Exactly how they came to be an area of child and family social work practice is not known. Researchers have speculated that it is a result of increasing medical knowledge about pregnancy, child development, and the long-term impact of exposure to risk factors in utero, as well as the long-term impact of early childhood experiences on individuals' life-

span development (Critchley, 2018b; Hart, 2001; Hodson, 2011). Social and cultural factors such as the impact of serious case reviews (SCRs) and the media response to these (Hart, 2001; Hodson, 2011), and increasing social fears of infanticide (Barlow et al., 2016; Critchley, 2018b) are also believed to have had an impact on the increasing focus on pre-birth work in child and family social work. Although no data is collated within the UK on exactly how many pre-birth assessments are completed each year (Mason and Broadhurst, 2020) the number being undertaken in England appears to be increasing. This evidence comes from research that explores the number of infants who are removed shortly after birth, which has been rising across the UK (Alrouch, et al.; 2020; Bilson and Bywaters, 2020; Broadhurst et al; 2013; 2014; 2018; Broadhurst and Mason, 2020; Pearson et al., 2020; Raab et al., 2020) as well as Europe and Australia (Harrison and O'Callaghan 2014, Harrison et al., 2020; Hestbæk et al., 2020). Broadhurst et al. (2018) found that court applications for infants more than doubled in England between 2007 and 2017.

Despite being a growing part of child and family social work practice for around 50 years, legislation and guidance has not developed at a similar rate. Unborn babies have no legal rights and no status of personhood (Hodson, 2011) but it is generally accepted that child protection processes for children can apply to unborn babies (Crtichley, 2018a). In England, pre-birth assessments are therefore underpinned legislatively by the Children Act 1989, like other aspects of child and family social work. This Act imposes a duty on all Local Authorities to "safeguard and promote the welfare of children" and to "promote the upbringing of children by their families" wherever possible (Children Act 1989,

S17(1)) and the statutory guidance *Working Together to Safeguard Children* (WTSC, HM Government, 2018) states that child protection processes can apply to unborn babies. It was not until the 'Working Together' guidance published in 1991 that any formal processes for protecting unborn babies was introduced (Hart, 2001). Since this time, there have been developments in local guidance, with all LAs referring to pre-birth practice in their procedures, although the detail and content varies (Lushey et al., 2017). The most recent publication of WTSC (HM Government, 2018) continues to reference practice with unborn children, albeit only specifying that child protection processes can apply to unborn babies, and LAs can develop their own local protocols for specific practice areas, such as pre-birth assessment. It is argued that current guidance is insufficient and does not account for the complex legal and ethical context that pre-birth assessments operate within (Lushey et al., 2017)

The evidence base for assessment, support and intervention is also limited for pre-birth assessment, although this is an area which is starting to receive attention. The limited evidence base had led to variations in practice across different LAs and teams (Mason et al., 2022a). Some LAs are using models for pre-birth assessment proposed by Corner (1997), Hart (2001) or Calder (2003) however, these approaches have never been reviewed or critiqued (Hodson, 2011) and there are arguments that these models need updating (Critchley, 2018b; Lushey et al., 2017). Other LAs are trialling new ways of working and some of these models have shown promise in practice (Mason et al., 2022a). This variation can lead to practitioners forming their own methods of completing assessments, resulting in significant variation in practice across England (Mason and Broadhurst, 2020). There is emerging evidence that

there is a tendency towards risk averse practice within pre-birth assessment, and that social workers may recommend removal of a child as a safer option to allow more time for assessment (Critchley, 2018b; 2020a) which goes against legislation and guidance which state that new-borns should only be removed for extraordinary and compelling reasons (Council of Europe, 2015).

The experiences of those involved in pre-birth assessments is a clear gap within the literature, when considering both families and professionals. There is limited literature around the experiences of family members, with two UK studies having explored this (Corner, 1997; Critchley, 2018b; 2019). Further articles explore the experiences of removal within the first week of birth (Broadhurst and Marson, 2020; Marsh, 2016; Marsh et al., 2019) but the impact on families is still relatively unexplored. Even less is known about the experience of professionals involved in pre-birth assessment work. Currently there is more literature available on the experiences of midwives involved in pre-birth child protection work (see Everitt er al, 2015; 2017; Marsh, 2016; Marsh et al, 2014; 2020, Marsh et al., 2019), although this research tends to focus on instances of removal at birth rather than assessment more holistically. Research that focuses on social workers' experiences is extremely limited. Critchley's (2018b) thesis and a subsequent publication (Critchley, 2020a) discuss some aspects of the experience of social workers involved in pre-birth assessment work in Scotland. Marsh et al. (2019) also explored the experiences of social workers involved in removal of babies at birth in Western Australia, however the processes around removal are very different in England and Western Australia and this study only considered removal, rather than pre-birth work more holistically.

The limited attention that pre-birth assessment has received in terms of guidance and research, coupled with the growth in this area of practice highlight then need for further understanding of how pre-birth assessments are undertaken, and the experiences and impact of this work in order to understand and develop practice. The next section will explore my own research journey and how I came to the decision to explore pre-birth assessment during my Professional Doctorate.

1.3. Motivations to research pre-birth assessment

My motivation to undertake this study is heavily influenced by my own experience as a child and family social worker. As Schostak and Schostak (2013) suggest, “No research is ever undertaken without a motive” (p.viii) and past personal experiences can be a driving force for researching a certain topic (Mallon and Elliott, 2021). Within all research, it is important that researchers reflect intensively on their own perspectives, their own experiences, and how these might have influenced their perception of the topic of study (Winter, 2014), even though this can evoke feelings of discomfort and vulnerability (England, 1994). As a social worker, I worked with several families where I undertook assessments before birth. I worked within a duty assessment team, where my work was often short-term and quick-paced – referral, assessment, plan, closure, or transfer. Pre-birth assessments offered something different; something more structured, with time to plan assessments and interventions rather than being reactive as situations unfolded. Although I had time to get to know families and build relationships, these were not always easy relationships, and they often challenged me as a professional. They were complex, with intertwined stories and difficult histories. There was never an

easy answer. I think these complexities and the different processes that they offered drew me to them. And I was not alone, many of my team were just as drawn to undertaking pre-birth assessment work, although I do not recall us ever discussing why.

After undertaking several pre-birth assessments, I was quite confident completing them and felt that I had a good approach to working with families before birth. This approach was borne out of learning through experience, from my peers, through supervision, and with Hart's (2010) chapter on 'Assessment Before Birth' echoing in my ears. Some of the work I am most proud of started as with families before birth and some of this work was commended by managers, Independent Reviewing Officers (IROs) and families. However, my work with one family changed my feelings about pre-birth practice. It had a significant impact on my professional identity as a child and family social worker, leading me to question my role with families and some of the decisions I was involved in. Having left front-line practice to work within education in 2015, it was not until I started my Professional Doctorate in Social Work in 2019 that I had the opportunity to unpick my thoughts and feelings about my work with this one family. During a module exploring ethics and professional identity, we chose a complex problem from our own professional experience to critically analyse the ethics around decision making, and the impact that this had on our professional identity. For me this module offered me a chance to re-visit my work with that family. I had hoped that this may be cathartic for me and serve to provide some closure to an experience that had a such a profound impact on me. The truth was it served to raise more questions than answers. I found very little research on pre-birth assessment and worrying

statistics about the rising number of infants being removed at birth. As a result, I decided to change my thesis topic to explore pre-birth social work practice.

What follows is a brief and anonymised account of my work with a family, particularly a mother and her unborn baby. The story can never be explained fully to maintain the confidentiality of all parties, other than my own part. I also recognise that my own memory of the event is fallible. As Aristotle said, a memory of an emotional event is like an experience “stamped on running water” (Loukas, 1932, p.171), recognising how our understanding and current context can shape our memories. The reality of the situation and my work with the family was much more complex, but key parts of the story are all included. I have named the mother Amanda for the purposes of this research.

At the time I met Amanda, I had undertaken several pre-birth assessments. Amanda had a complex history of her own, as well as an older child who was no longer in her care. As with several of the pre-birth assessments I was involved in, the worries were complex and intertwined with concerns around mental health, substance misuse, domestic abuse and neglect. Amanda and I developed a good working relationship, she showed insight into the concerns and did everything we suggested to show that things could be different, that she had the potential to provide safety for her unborn baby. She was excited about the birth of her baby. Whenever I visited, she showed me some of the new things she had bought to prepare for their arrival; tiny clothes often being hung on the line outside, washed and ready for her baby. This contrasted starkly with the worries about Amanda’s previous parenting capacity that led to the removal of her older child - worries that were very serious and not that distant in terms of time. There was a real chance that Amanda would not be

able to maintain her progress once she had a tiny crying baby in her care, a matter we had discussed during the assessment. Despite that, I felt that the risks were manageable and did not warrant the baby being removed from her care after birth. Short of having a crystal ball to see the future, we could never know what would happen once the baby was born, but I had wanted a very clear and structured child protection plan in place and for work to continue with Amanda and her baby after the birth.

On reflection, I think my work with Amanda was completed in a silo. I cannot remember whether I discussed Amanda and her baby in supervision or not, but my experience of my final supervision before my assessment was concluded would suggest that it was never discussed in any detail. During that final supervision, I was informed that the baby remaining in Amanda's care was not an option, the only option was to recommend removal. I felt dumbfounded. Maybe this was the right decision, but it felt as though I no longer had control of my assessment and the whole process had been futile. The argument was that the risks were too high with her older child being removed so recently. I was seen as being overly optimistic and too involved with Amanda, rather than thinking about the unborn baby. I tried to argue my case, explain my reasons, but they felt unheard. The other professionals involved agreed that the plan should be removal, and my assessment was a multi-agency assessment; not just my own decision. Eventually I simply withdrew and started to question my own ability instead. I must have been wrong. I must be a bad social worker. Maybe I am doing more harm than good. Maybe I should have hammered home that the baby might be removed every

single time I saw Amanda just in case that was what would happen. Maybe I cannot be trusted to work alone with families.

Ultimately, I had to change my outcome and inform Amanda that my assessment would be recommending that her baby was not to remain in her care after birth. I was numb, this was not something I wanted to do. I am good at hiding my emotions and often appear to be coping with things when I am not, which may be why most people did not notice my conflict. Thankfully a colleague recognised the signs that I was struggling and offered to come and speak to Amanda with me. A small kindness for which I am eternally grateful, as the visit was predictably difficult. I still didn't feel that removal was the right thing to do and seeing Amanda in so much distress is something that has stayed with me. At this point, I wanted Amanda to fight it. I wanted the Judge to throw out any care plan and report I put forward after the baby's birth. I wanted Amanda to continue with her progress and prove what I felt was possible; that she could care for her baby. I was hoping the other professionals would be proven wrong, not for my own wellbeing or out of spite, but because I continued to feel it was the right thing to do. All whilst silently questioning my own ability and wondering if in fact I was the person that was wrong.

From the day that I told Amanda that she may not be able to take her baby home from the hospital, everything started to fall apart. She fell back into the behaviours that we were worried about and trying to make her see that this was reducing her chances of caring for her baby did not make a difference. I felt useless as I watched her progress fall by the wayside. Others saw this as evidence that they were right and that she would not have been able to hold herself together when she was home alone with a crying baby, that it was

inevitable that she would revert to old behaviours. I saw it differently. I wondered how much strength it would take for any person to be able to hold themselves together when they have been told they may not be able to take their baby home. Especially when you consider Amanda was someone with long-standing needs of her own. I wondered what I would do in those circumstances, as someone who hadn't faced the same challenges, or experienced the same abuse – could I have held it together? Might I have given up too? I wondered how Amanda would have responded if the outcome had been that we were not seeking a care order, would this have given her the confidence and drive to continue a path where she was neatly washing and folding her unborn baby's tiny baby grows, buying toys and decorating the nursery? Would that have been enough? Would she have proven me wrong when the baby arrived and reverted to old behaviours anyway? These questions have stayed with me over the many years that have passed since this time, despite knowing I will never be able to answer them.

I was sad as I watched Amanda spiral back into a place where she and her unborn baby were at risk of so much harm. I felt powerless to affect any change, our relationship was now difficult, and I could understand why. Rightly or wrongly, I felt some personal responsibility for the dangers both now faced; the assessment outcome was undoubtedly a contributing factor to things falling apart at this point, an assessment which had my signature on it, the words had come from my mouth.

By the time Amanda's baby was born, any possibility that she could be seen as having the parenting capacity to care for a newborn baby was gone. A Judge agreed and granted a care order. I removed Amanda's baby from her

care when they were only a few days old. That was one of the worst days of my life, and it feels selfish to say that, as it was almost certainly one of the worst days of Amanda's life and I was the villain in Amanda's story. I went to the hospital with an empty car seat and left with Amanda's baby some hours later.

Whilst there was no other option by this point, I was still plagued with doubt that this had been the right thing and questioning how it could have gone differently. This was made much worse by two midwives on the ward. They pulled me aside when I arrived and asked if there was any way Amanda could keep the baby, she had been doing so well and needed no support. They couldn't see the risks to the baby. I blankly uttered, "We have a care order". I wanted to cry. What did they expect me to say? I doubt any emotion crossed my face as I was trying so hard to keep myself together and I knew that breaking down would not make this better for anyone. I felt as though they must have seen my robotic response as proof that I felt nothing, but that was so far from the truth. I spent time with Amanda and the baby, as she dressed them and talked me through their routine. I remember wondering how she was able to stay so calm, it was clear she was upset but she was just focused on her baby. She held herself together so well as I sat by the bed working so hard not to fall apart. As I left the room, I heard her break down. She was not alone, she had someone with her, but it was heart breaking. Walking through the ward, still able to hear Amanda sobbing inconsolably is something I will never be able to forget. It felt surreal that I had any authority to leave a hospital with someone else's newborn baby in this way. I remember walking through the labyrinth of hospital corridors, avoiding people's gaze, worried they might

congratulate me or even worse, know what I had done. I took the baby to the foster carers and went through the care plan, all in a daze. I do not remember anything about the journey there.

Once the baby was settled, I got back in my car and drove straight back to my office, even though I was supposed to be going home and it was after 5pm. I knew I could not go home. I knew my partner would not be able to understand what was wrong with me. I wasn't sure anyone would be able to understand how I was feeling, or even that I understood how I was feeling. On top of all of that, I felt selfish for even feeling anything. The second I walked onto my office floor and made eye contact with a colleague and close friend, I broke down. I was hysterical, I couldn't contain it any longer. I have never cried so hard. I don't remember going home, I don't even know if I drove or if someone drove me. I spent the weekend feeling completely numb and unable to do anything. It sounds dramatic, but time seemed to pass like a timelapse montage from a film, sunrise to sunset, sitting on the sofa staring out the window.

Numbness was replaced by anger in the coming weeks. I realised I should never have gone to the hospital on my own. Even though I tend not to show my feelings, it should have been assumed that leaving a hospital with a newborn baby is something that requires support. Even without all the internal conflict I felt about Amanda and her baby, removing a newborn baby is not something that anyone should do without significant support. I knew that this was something I needed to raise and when the opportunity arose, I discussed it with someone more senior. The discussion did not go as I anticipated. I felt cut down. I was told that if I could not cope with that, then maybe I should not be a social worker. A comment that has stuck with me, a comment that I

wholeheartedly disagree with. I firmly believe the very opposite of this - that if I could deal with that situation without it having an impact, that maybe *then* I should not be a social worker. Leaving a hospital with a newborn baby should always feel difficult, and I would be seriously concerned if someone told me they did not feel anything about this. I do not imagine the person I spoke to at the time would remember saying it, and they might have a view that it was said in a different way, but the point felt clear to me; I was not strong enough to be a child and family social worker.

My work with Amanda and her baby sparked the beginning of the end of my time in front-line social work practice. I started to question if what I was doing was right when at times it could feel so wrong. I felt that I lost a piece of myself somewhere in working with Amanda and her baby. There were other factors that led me to leave my post, but my work with Amanda and her baby was certainly a tipping point for me. I was a social worker who actively chose to be involved in pre-birth assessments, despite finding them complex and challenging. I still feel that some of my best work with families was done before some of the babies were born and I have many fond memories of working with mothers, fathers and grandparents. I was even asked to be God Mother to one of the babies whose parents I had worked with, and even though I never could have accepted that invitation, I would say some of my proudest work as a social worker was with that family. Yet for me, one pre-birth assessment took the shine off my other work and had a profound impact on me, both personally and professionally.

As with Hart (2001), Hodson (2011) and Critchley (2018b) before me, it was my experience in practice that drove me to explore the topic of pre-birth

assessment. Whilst our motivations and experiences differ, there are clear similarities between our stories in terms of questioning practice and the ethics of the work. My experience of working with families combined with my discovery of the scarcity of research which explores pre-birth practice have fuelled my desire to fill the gap. To my mind, pre-birth social work is one of the most complex areas of practice, fraught with ethical dilemmas. Critchley (2018b) reflected on this motivation at the start of her thesis and captured this so perfectly that I could not put it any other way:

> "Pre-birth work appeared to trouble a small number of social workers so much that they would devote years of their lives to preparing a thesis on the subject. I realised I was one of them." (p.13)

Whilst I knew it would be a difficult topic for me to research, I began to realise that this was actually a reason to do it; as I was clearly not alone in feeling this way. It is my hope that by understanding the experiences of social workers in more depth we can learn how to effectively support them working with unborn babies and their families. And that in doing so, social workers will be better placed to support the families and unborn babies they encounter.

1.4. Research questions

The aim of this study it to gain an understanding of social workers' experiences of undertaking pre-birth assessment and associated work with families. The objectives are:

- To explore social workers' understanding of pre-birth assessments and how these relate to other aspects of children and families' social work.

- To explore the impact on social workers of undertaking pre-birth assessments and how they feel about this work.
- To establish what support social workers have received when working with families before a baby is born, or how they would like to be supported.

These questions were answered through a small-scale qualitative study within one geographical area of England. I will outline in the research methodology and methods chapter (Chapter 4) why this method was chosen and how these fit with the aim and objectives of the study.

1.5. Structure of the thesis

This thesis is separated into eight chapters. Following this introduction, Chapter Two explores the wider socio-economic and socio-political landscape of child and family social work. This chapter explores the development of the current 'child protection' paradigm, exploring historical developments in child and family social work and the impact of political ideology and policies on how child and family social workers operate. This chapter also considers the role of the media and high-profile cases of child abuse in shaping practice. The unique nature of the North East of England, where this study is based, is also considered.

Chapter Three is a critical review of the current literature on pre-birth practice which will answer the question, 'What is known about pre-birth practice in social work?'. Whilst this is a very broad question to pose, it felt necessary to draw together what is currently known about pre-birth work due to the disparate nature of the current research on the topic. The literature review

gives a comprehensive underpinning to the study and much of this research is later drawn upon within the finding's chapters. The literature review is focused on social work practice, but incorporates research from other professions such as midwifery, where the learning can be applicable to social work. This chapter serves to highlight where there are gaps in the current understanding of pre-birth practice.

Chapter Four outlines the methodological approach to the study, and the methods used to collect and analyse the data. This chapter starts with an exploration of reflexivity and my own positionality in relation to the study, with detailed discussions around the benefits and limitations of being an insider researcher and how this was utilised within the study. It goes on to outline the research problem and aims of the study, before considering methodological approaches and discussing how a critical realist approach aligns with the research question. Ethical considerations are explored before moving on to a detailed outline of how the study was designed and undertaken. This section considers why interviews were an appropriate method for data collection and how they were designed and conducted. Recruitment and sampling are discussed in detail, including some of the difficulties with recruitment and how the approach was adapted in response to these. The emotional labour of researching a topic motivated by personal experiences and the unanticipated impact on me as a researcher are explored, considering the implications of this for the study. The transcription process is detailed and the approach to analysis, using Reflexive Thematic Analysis (Braun and Clarke, 2021) is explained in detail.

The findings of the study are contained within three chapters centred around the three separate themes. Throughout these chapters the findings are critically analysed and wider literature is drawn upon to interpret their relevance and how they align with the current understanding of pre-birth practice.

Chapter Five is the first of three findings chapters, titled ‘The unique complexity of pre-birth work’. This chapter is centred around what makes pre-birth assessment work distinct from other areas of practice within child and family social work. Whilst recognising that all social work practice can be complex, this chapter argues that pre-birth practice brings additional challenges in terms of the pressure of making decisions about children before they are born. This theme also discusses the challenges of assessing unborn babies who are invisible during the process. This invisibility inherently presents social workers with a challenge, but also leads to conflict when deciding who should be the primary ‘client’ for the work in lieu of a child to work with and observe. Assessing parenting capacity in the absence of a child is also a complicating factor which is explored within this chapter.

Chapter Six is titled ‘Trying to do the ‘right’ thing’. This chapter is framed using Thompson’s (2021) PCS model and explores the layers of complexity around decision making within pre-birth practice and how this influences experiences of social workers and the outcomes for families. First this considers the individual actions of the participants and what they did themselves to ensure that their practice with unborn babies was ‘right’. Here participants’ discussions around doing a thorough assessment, building relationships based on honesty and maintaining openness to change, are explored. Next this theme considers

the impact of organisational culture on the work, exploring the impact that managers and other professionals, previous involvement, and time can have on the outcomes of pre-birth assessments. This section focuses on the impact of these factors on the individual social workers and how they feel about the work they are doing. Finally, this chapter considers the influence of systemic factors, including funding and resources, with participants raising concerns that the 'right' outcomes might not be possible within the current system or within their LA.

Chapter Seven is the final findings chapter, titled '"Wildly underprepared and really scared": practical and emotional support with pre-birth work' This chapter explores how social workers prepare for the work and 'learn' how to work with families before birth, and then how they are supported during the work. This theme highlights how unprepared the participants felt for the work and that preparation is often limited to reading other social worker's assessments and learning through experiences. The emotional nature of pre-birth work is something that all participants agreed upon, but the support that they received to manage this differed greatly. The last section of this chapter draws on both examples of positive support systems and instances where participants felt alone and sometimes criticised or blamed in the work. The impact of support is explored, considering the importance of this and the potential impact that it has on social workers.

Chapter Eight summarises and concludes the thesis. This chapter considers how the aims have been met and explains the original contribution to knowledge that this study offers. Based on the findings, it identifies the implications practice, education and research, where several

recommendations are made. The limitations of the study are considered. The thesis is then drawn to a close with a conclusion.

2. Situating the research within the broader social, political and economic landscape

2.1. Introduction

This chapter will discuss the wider context of child and family social work that pre-birth social work practice is situated within. Child protection and child welfare systems exist to ensure that children are supported and protected from harm (Gilbert et al., 2011). How this is approached is determined by the historical, political, social and value contexts of a country (Cameron and Freymond, 2006). The chapter will begin with a brief exploration of the history of child and family social work and the development of the modern 'child protection' system which is dominant in Anglophone countries (Gilbert et al., 2011) before considering the political influence of neoliberalism and austerity policies on how services are delivered. The impact that high-profile cases of child abuse and murder, and the subsequent media coverage of these will then be discussed, considering how these have contributed to a 'politics of outrage' that have further impacted approaches to child and family social work. Finally, the chapter will consider the local setting of the study, within the North East of England and how the socio-political and socio-economic context of this area has impacted on children and families and the social work services that support them.

2.2. Child and family social work: a brief historical context

Until the middle of the 19th century, state interference into family life was infrequent (Fox Harding, 1997) with the welfare of children becoming more of concern since Victorian times (Pierson, 2011). Childhood was not perceived the same way as it is now, with many children being expected to work, often

in high-risk situations (Cunningham, 2005) and being tried as adults in law (Eekelaar, 2006). As a result, the welfare of children was seen very differently, with their protections coming under the Poor Laws, which afforded children the opportunity to work for their basic care (Cunningham, 2005). From the turn of the 20th century social attitudes towards childhood started to change and the state sought to intervene to improve the health, education, and social circumstances of children (Burman, 2017). This change aligned with the advent of psychology and study of child development (Burman, 2017) which continues to influence thinking to the present day.

The formation of the National Society for the Prevention of Cruelty to Children (NSPCC) in 1889 heralded a new approach to addressing child abuse. The organisations' campaigning, lobbying and publication of cases of child maltreatment resulted in the passing of the 1889 Prevention of Cruelty to Children Act (Corby et al., 2012). The Act empowered agencies to protect children within their home and remove them to a place of safety if necessary (Lonne et al., 2014). This period from the early 20th century provided many of the foundations of what has come to be known as the 'child protection system' (Corby et al., 2012; Lonne et al., 2014). At this time the NSPCC inspectors were considered "inspirational" by members of the public (Leigh, 2017, p.1) and were respected by communities (Corby et al., 2012). They were perceived as highly valued professionals, for the work that they undertook with children and families (Ferguson, 2011). This view of child and family social workers does not continue to the present day, with social workers being vilified by the media, the government and the public (Leigh, 2017), a topic which will be explored later in this chapter.

Public perception of childhood was further reframed following the second world war, with children being seen as vulnerable and in need of protection (Sims-Schouten et al., 2019). An inquiry into the death of Dennis O'Neill, who was killed by his foster carer in 1945, led to the Children Act 1948 (Corby et al., 2012) and the creation of Local Authority Children's Departments (Ferguson, 2011). The focus at this time was a preventative work (Corby et al., 2012), where families were supported to care for their children within their own homes (Lonne et al., 2014). Approaches such as psychoanalysis and attachment theory underpinned work that saw therapeutic relationships as key to supporting families (Ferguson, 2011). During this time, child welfare social work "operated quietly and confidently and in a relatively uncontested way... [allowing] wide professional discretion" (Lonne et al, p.21), away from the gaze of public and political scrutiny.

Child abuse re-emerged as a social problem in the UK and other Anglophone countries in the late 1960s and 1970s with Kempe et al.'s (1962) identification of 'battered child syndrome' in the USA (Lonne et al, 2013) and Griffiths and Moynihan's (1963) use of the term 'battered baby syndrome' in an influential medical article in the UK (Corby et al., 2014). This was followed by the high-profile murder of seven-year-old Maria Colwell by her stepfather in Brighton in 1973, who was killed despite social workers and other professionals being involved (Ferguson, 2011). The enquiry following her death was the first of its kind and attracted media and public attention (Corby et al., 2012). Throughout the 1980s, further public enquiries into child deaths which focused on individual failures of professionals led social work intervention to be seen as "too soft and permissive" (Corby et al, 2012, p.37), calling the approach to child

welfare which had focused on family support into question. Conversely, in 1987, 121 children were removed from their parents' care by social worker following ‘diagnoses’ of sexual abuse by two paediatricians in Cleveland in the North East of England (Ferguson, 2011). In this instance, social workers were criticised for being overzealous, and their approach being unjustified by both politicians and the media (Lonne et al., 2014). A similar situation occurred in Orkney less than five years later, where staff suspected children were being sexually abused and children were removed from their parents without full assessment (Munro, 1996). Both situations received heavy criticism through inquiries which were very public in nature (Munro, 1996). The contradictory nature of social workers being seen to be either not doing enough to protect children, or being too forceful in their approach had a significant impact on legislative reform (Ferguson, 2011). It was within this narrative of crisis that the current child protection legislation was constructed (Parton, 1991), with the introduction of the 1989 Children Act, which was first implemented in 1991 (Corby et al., 2012).

Child and family social work has undergone significant changes and developments over the years. One of the most notable changes is the shift from being a helping profession to being increasingly focused on risk and surveillance (Healy and Darlington, 2009; Lonne et al., 2014). Decades of political and economic changes have shifted the focus from the concept of family support to providing a narrower focus on child protection and child-centred intervention (Abdullahi, 2021; Fenton, 2021). This shift was brought about by the public outcry over the alleged failure of social workers and welfare agencies to prevent children from being killed by their parents and caretakers

(Featherstone, 2019; Howe, 1992) as well as changes within the dominant ideology in the political landscape of the UK (Parton, 2014); with neoliberalism being the overriding discourse since Thatcher's reign as Prime Minister. Critics of these changes see that policy and practice changes have emerged "in response to failure and in a context of crisis" (Lonne et al., 2014, p.17), resulting in a highly bureaucratised system (Munro, 2010) focussed on risk, investigation and assessment (Lonne et al., 2014), rather than focusing on the social factors affecting children and young people (Featherstone et al., 2017; Parton, 2014) and providing assistance (Lonne et al., 2014). Some of the political and social catalysts for this change and more recent developments in child and family social work will be explored in the remainder of this chapter.

2.3. The influence of neoliberalism

The contexts in which social work operates have been dominated by neoliberal ideology for more than 30 years (Morley et al, 2020; Spolander et al., 2014). Prime Minister Margaret Thatcher and her 'New Right' politics are seen as foundational in the introduction of neoliberal policies in the United Kingdom (Butler-Warke et al., 2020; Ferguson and Lavalette, 2013; Murphy, 2019) however neoliberal ideology has continued to dominate UK politics in successive governments (Evans, 2009; Garrett, 2009; Harris and Unwin, 2009; Rogowski, 2010; Rogowski, 2015a). The central tenet of neoliberalism is defined by Rogowski (2015b) as "the belief that the free market and free trade are best suited to meeting human wellbeing" (p.54) and that human wellbeing is best achieved through individual entrepreneurial freedom which is characterised by free markets, free trade and strong private property rights

(Harvey, 2005). It involves reduced public expenditure and privatisation of nationalised industries (Rogowski, 2015b).

Successive governments utilising a neoliberal approach has marked implications for both the social work profession and the populations that it serves (Morley et al., 2020). For the social work profession, and specifically child and family social work, neoliberalism has had a significant impact (Butler-Warke et al., 2020). Neoliberal discourses have shaped the practice of social workers, promoting “an uncritical, passive, technique-driven, formulaic, rule-bound and competency-based style of practice” (Morley et al., 2020, p.3). Clarke (2004) argues that neoliberal ideas are implemented through the “organisational glue” (p.128) of managerialism. Through this, there has been a shift from LAs having autonomy to utilise their funding to serve local needs based on professional judgement, to a more managerially led role (Rogowski, 2015a). This approach has led to an increased focus on audit, performance management within social work (Clarke, 2004), leading to decrease of worker autonomy with targets and outcomes being seen as more important than the quality of relationships. Neoliberal policies and managerialism have led to increasing technical responses to complex human issues which focus on risk assessment and risk management (Morley et al., 2022) and a view that issues are individual, and people must take personal responsibility for them, ignoring wider systemic influences (Featherstone et al., 2012; Parton, 2014).

Neoliberal ideology has also led to a shift from a welfare approach to a child protection approach in child and family social work. The child protection paradigm is now dominant across many Anglophone countries (Lonne et al., 2009). Within this there is a child centric focus on protection children from risks

posed by their families and care givers, rather than a broader focus on child welfare and supporting families (Featherstone et al., 2014). Whilst prevention and family support feature within policies, Lonne et al. (2009) argues that these come secondary to the primary role of intervening to protect children from harm. This was recognised and criticised in the Munro report following Peter Connelly's death (Munro, 2011), yet little has changed as a result of Munro's recommendations (Fenton, 2021). The introduction of the Children Act 1989 was argued to implement, "a change from working therapeutically with children and families to protecting children by means of surveillance and control" (Rogowski, 2015b, p.56) and the impact of neoliberalism has further cemented this approach, with "social workers becoming investigators and parents becoming objects of enquiry" (Rogowski, 2018).

Neoliberalism has resulted in a reduction of state universal welfare, with an emphasis that people need to be able to take responsibility for their own lives, leaving social workers to provide targeted and authoritarian intervention in response to risk (Rogowski, 2018). The current child protection paradigm fits within this individualistic approach to social problems (Featherstone et al., 2014). Neoliberal ideology has also led to increasing restrictions on resources, especially under austerity measures which will be discussed in the next section of this chapter. Yet, at the same time, the people whom social workers work with have been subjected to increasing levels of poverty and economic inequality (Featherstone et al., 2012). The dominant discourse of individual responsibility is used to justify punitive social reforms, and there is a sense of precarity caused by employment insecurity and flexibility (Brown, 2022; Garrett, 2010).

Neoliberalism has been described as a “crisis in social work” (Lavalette, 2019), in that it promotes the rationing of resources, increased bureaucratisation, de-professionalisation and individualisation (Rogowski, 2012). Within this, children are seen as separate to their family, and parents as subjects of investigation and intervention, rather than individuals with a need for support in their own right (Featherstone et al, 2014) which affects how child and family social work recognises and supports their needs.

2.4. The impact of austerity

Austerity is a policy associated with neoliberal ideology (Brown, 2022). Cummins (2018) argues that it is “a more potent form of the same brew” (p.148). As a concept, austerity is “hard to define” (Mort, 2017, p.312). It was presented by the Liberal Democrat and Conservative coalition government following the 2008 financial crisis as a “necessary” and “inevitable” step to “economic recovery” (Osbourne, 2009, p.1) in response to a national economic emergency (Cummins, 2018). The government stated that the aim of austerity was economic; to reduce public spending to decrease the financial deficit (Cummings, 2018b). The reductions in public spending through austerity measures equated to the biggest financial cuts to public services since the Second World War (Crawford, 2010). Rather than being economic, many argue austerity measures were in fact a politically chosen strategy to reduce the welfare state (Cummins, 2018; Jones, 2018) in line with the new right ideology. The UN Special Rapporteur on extreme poverty and Human rights reported that when, “a booming economy, high employment and a budget surplus have not reversed austerity” it is evidence that austerity is “a policy pursued more as an ideological than an economic agenda” (Alston, 2019, p.1).

Social work organisations have been critical of austerity. It is defined by the British Association of Social Workers (BASW, 2017) as “economic and social policies… that result in reduced public and welfare spending, a smaller state and more unequal distribution of wealth” (p.1). The International Federation of Social Workers (2016) have described austerity as,

> “a flawed economic theory that increases debt burden, unemployment, homelessness, inequality and causes misery upon the lives of citizens… [that] the method of reducing public expenditure combined with tax reduction for the wealthy reduces state income and fails to achieve balanced economies. This results in the widening of the gap in inequality and increases poverty.” (n.p)

This is because austerity measures have had a profound impact on the welfare state (Cummins, 2018a; 2018b) and have affected the quality and availability of public services over the last decade (Hernandez, 2021; Webb and Bywaters, 2018; Webb et al., 2022). They have also led to a much more divided and unequal society (Cummins, 2018) which has had a direct impact on children and families. Whilst the Prime Minister David Cameron made a commitment to protect the most vulnerable as part of the austerity and welfare reform (Vizard et al., 2023), evidence suggests that these policies have disproportionately negatively affected families with children (Joseph Rowntree Foundation, JRF, 2020; Tucker, 2017).

Austerity measures have led to increasing levels of need and have had “tragic social consequences” (Alston, 2019, p.1). Unemployment, poverty and homelessness have all increased over the time of austerity measures, which

have negatively impacted on the health of society, especially those who were already most vulnerable (Walsh et al., 2022). Austerity measures have led to increasing levels of poverty within families (Pantazis, 2016), with this disproportionally affecting lone-parent families (Schmueker et al., 2022). The stress of poverty is associated with increased levels of mental illness, substance misuse problems (JRF, 2016), and people living in poverty have a higher chance of experiencing domestic abuse and violence (JRF, 2016). These are factors that can impact on parent's capacity to meet their children's needs. Through austerity measures, services to support people with these needs have received reduced funding, with the quality and availability of services diminishing (JRF, 2016; Roscoe et al. 2021). Waiting lists for mental health services have grown (Cummins, 2018b) and there has been an increase in suicide rates (Mills, 2017) and alcohol and drug-related deaths (Roscoe et al. 2021). These factors have led to increasing demand for child and family services across the country, although there has been significant variation between regions and LAs (ADCS, 2021). In their safeguarding pressures report, ADCS (2021) stated:

> "The reasons why children and families require support has changed little, but has become more pronounced. More children are living in families where there is reduced parenting capacity through domestic abuse, mental ill health or substance misuse. The impact of deprivation and housing issues is putting more families in acute stress and financial difficulties." (p.119)

It has become more difficult for families to access support under austerity measures and neoliberal ideology (Cummins, 2018), with a focus on

investigation and risk, rather than welfare support. Austerity measures have led to early help services being “heavily and inequitably defunded in the 2010 decade” (Webb et al., 2022, p.3). This has led to increasing rates of unmet needs for children, as services which have previously supported families have been defunded (Hood, 2020). Hood (2015) argues that this has led to children’s services being overwhelmed, with limited early intervention services available families have instead come to the attention of social work services. Here they “keep reappearing and cumulatively start to overload the system’s ability to cope” (Hood, 2020, p.10). Between 2011 and 2018, Webb and Bywaters (2018) found that whilst safeguarding expenditure remained relatively stable, spending on early intervention and support services consistently decreased, whilst spending on looked after children increased. They concluded that under austerity measures, there has been a move away from family support to a focus on child protection and permanent alternative placements for children because of reduced budgets for universal and early intervention services, and that this change in focus has impacted most significantly on children and families in deprived neighbourhoods. Webb et al. (2022) found that deprivation and funding impacted on the quality of children’s services, which has left the “most deprived local communities with the greatest needs [being the] least likely to have access to good quality children’s services” (p.16). This is especially pertinent to consider for research undertaken in the North East of England, and this will be explored further later in this chapter.

2.5. Moral panic and risk averse practice

This section will explore the role of the media in shaping public perception, social policy and child and family social work practice. Public perception and attitudes are heavily influenced by the media (Jones, 2012) which in turn impacts on social policy. Media outlets both reflect what they believe the public is thinking and promote ways of thinking by deciding what is important enough to publish and what is not (Leigh, 2017). In addition to influencing public perception, the media can also affect government decisions by creating moral panic (Leigh, 2017). Moral panic was a concept first discussed by Cohen (1972) in his examination of widespread social alarm over a variety of issues during the 1960s and 1970s, most famously the depiction of the Mods and Rockers in the 1960s (Clapton et al., 2013). Cohen (2002) is keen to point out that moral panic does not mean that, "there is 'nothing there'... but that the reaction to what is observed or inferred is fundamentally inappropriate" (p.172), and that this response is disproportionate (Clapton et al., 2013). Several authors have commented on how the media sensationalism regarding child abuse and murder over recent decades has led to public scrutiny which has ultimately had an impact on social workers and the work they do (Ayre, 2001; Clapton et al., 2003; Leigh, 2017; Lonne and Parton; 2014).

Public scrutiny and media focus regarding child abuse and child fatality is not a new phenomenon. The media have published stories on child deaths since before legislation and professional networks to respond to child abuse existed (Powell and Scanlon, 2015). As was outlined earlier within this chapter, following their conception in the late nineteenth century the NSPCC originally used the publication of child deaths and abuse in the media as a tool to gain

public backing and lobby the government to promote social change and the introduction of legislation (Corby et al., 2012). After 1918 this media attention reduced (Lonne et al, 2014), before re-emerging in the 1970s and 1980s (Corby et al., 2012; Ferguson, 2011), but with a very different focus. In the early 1900's, when a child died it was not seen to be the fault of the practitioners involved, yet social workers have been individually and collectively vilified by both the media and the public over the last 30 years (Leigh, 2017). Whilst social work was once viewed as an inspirational and respectable profession (Leigh, 2017) has more recently been painted as a failing professional. This is at least in part because of the profession's perceived role in high profile cases where children have died (Corby, 2005). The collective emotions and outrage felt by the public in response to child deaths and the media portrayal of these have become political (Warner, 2015).

From 2008-2010 there was a cluster of media stories about child abuse which focused on the failings of social workers, which included the deaths of Peter Connelly and Kyra Ishaq and the kidnapping of Shannon Matthews (Jones, 2012). Peter Connelly's death led to the highest levels of moral panic of any child death in history (Butler, 2016). The media response to Peter Connelly's death was extensive and highly critical of the services involved, but especially the social workers (Murphy, 2019; Parton, 2014; Warner, 2015). The Sun newspaper launched a petition that all social workers involved should be fired and not allowed to work again through their 'Beautiful Baby P: Campaign for Justice' (The Sun, 2008, cited in Jones, 2012), with other media outlets, including print press, radio and television coverage, following suit (Jones, 2012).The media coverage quickly became "politicized and scandalized to a

new level of intensity" (Parton, 2014, p.69) when the then leader of the opposition Conservative Party, David Cameron appeared across the media expressing outrage at the failures (Jones, 2012). Utilising a "politics of outrage" (Parton, 2014, p.79), the Conservative Party casted doubt on the current child protection system and stated that meaningful reform would only be achieved through a Conservative administration (Warner, 2015). The negative news served right-wing political parties who sought to reduce the welfare state (Galilee, 2005) and became an established and accepted narrative repeated by the Conservative Party in the run up to the general election of May 2010 (Parton, 2014).

This media focus on high profile cases of child abuse has led to a "culture of blame" (Munro, 2010, p.38) which has continued to affect the nation's view of child and family social work (Warner, 2015). Either consciously or unconsciously, this has impacted on social workers ways of thinking. It has led to a climate of "fear" and "anxiety" (Munro, 2010, p.17) with the media attention and political outrage over child abuse arguably undermining the collective confidence of social workers (Elsey, 2010). This has had an impact on social work practice and decision making (Murphy, 2019). The outrage and attention following the death of Peter Connelly resulted in social workers and other childcare workers being hypervigilant in ensuing that other children were not suffering in the same way (Parton, 2014; Warner, 2015), and that they would not be named and blamed for the next high profile child death in the media (Murphy, 2022). Munro (2019) refers to concern about being 'blamed' as the "risk-to-self averse" (p.125) practice. She argues this simply displaces the risk and subjects children and families to potentially unnecessary distressing

experiences, and places services under more pressure when involvement could be avoided.

The impact of Peter's death on social work continues to shape practice, affecting how social workers view how children can be kept safe within their families (Murphy, 2019). Following Peter Connelly's death in 2007 and the media scrutiny around services involvement, there was an increase in referrals, child protection plans and care proceedings that has lasted for years (Brooks et al., 2012), which Shoesmith (2016) referred to as the "Baby P effect" (p.18). This has not diminished in the years since Peter death and arguably still has an impact on child and family social work (Murphy, 2019). The number of investigations for suspected child abuse has continued to grow (Bilson et al., 2015; Devine and Parker, 2015; Samuel, 2022) and the number of children in LA care has increased every year since 2010 (NSPCC, 2021b). Featherstone et al. (2016) commented that whilst the number of child protection enquiries had risen by 79.4% over a five-year period, the number of children on child protection plans had not risen in line with this, suggesting a pattern of over investigation. The most recent statistics suggest this pattern has continued with a rise in section 47 enquiries (Children Act 1989) from 2018 to 2022, but a steady decline in the number of enquiries leading to Initial Child Protection Conferences (ICPC) since 2013 (Department for Education, DfE, 2022). Despite the increased intervention of the state, the number of children who have been killed as a result of abuse or neglect in the UK has remained constant at approximately one child a week in recent years (NSPCC, 2021a). Over a longer period of time, Prichard and Williams (2010) found that between 1974 and 2006 child abuse related deaths have actually reduced significantly.

Despite this, the media continue to have a preoccupation with attributing blame and publishing scandal around incidents where children have been seriously harmed or killed (Butler, 2016; Vincent et al., 2020). Arguably, negative stories sell newspapers by grabbing the public's attention (Warner, 2015) so it is in their interests to publish such articles. However, this promotes an unrealistic view to the public that child abuse can be eradicated, which Munro (2011) discussed in her review of child protection. Other academics have also argued that it is not possible to eradicate child abuse and murder due to the unpredictability of people (Ferguson, 2011; Parton, 2014; Jones, 2014). Instead of driving down the number of child deaths, the media and politicalisation of child abuse appear to have contributed to risk aversion and over investigation in child and family social work. This alongside ideological shifts which have promoted audit, managerialism, compliance, a child centric focus, and reduction in resources, have resulted in a set of circumstances for risk averse and fear-based practices to take hold. Media scrutiny of social work is of particular contemporary relevance as shortly before the conclusion of this thesis, Finley Boden's parents were found guilty of murdering him at 10-month-old on Christmas day in 2020. Finley had been removed from his parents' care days after birth following a pre-birth assessment being undertaken before being returned to their full-time care nine months later (Murray, 2023). The Serious Case Review regarding his death has not yet been published but given his age and the situation, this is likely to lead to public, political and media scrutiny around pre-birth social work practice.

2.6. The local context: the North East of England

This research study has been undertaken within the North East of England, where I continue to work within social work education. The discussion thus far has been on England as a whole but it is important to consider what factors differentiate the North East in particular.

The North East of England is the smallest region in England, in terms of both area and population (Brooks and Steer, 2021; Duke et al., 2006). From the middle of the 19th century, the main economic strength of the North East was its industry which included coal, steel, shipbuilding and heavy engineering (Brooks and Steer, 2021). Changes to national and local economy and the increased globalisation of industry in the latter part of the 20th century resulted in a decline in manufacturing in the region (Centre for Local Economic Strategies, CLES, 2014a). This was accelerated by the government withdrawing subsidies to heavy industry in the 1980s (Brook and Steer, 2021). The decline of industry in the area has led to higher rates of long-term unemployment, sickness, disability and dependence on benefits (Duke et al., 2006). The reduction in industrial jobs was replaced with a rise in public sector and service industry roles (CLES, 2014a; Brooks and Steer, 2021) however the North East has consistently experienced lower employment rates than the South of England for several decades (Office for National Statistics, ONS, 2012). Within the region there is also diversity, with some areas catching up economically (Duke et al., 2006) however, the densely populated east-coast areas of the region continue to have high levels of deprivation (Brooks and Steer, 2021).

The North East of England has some of the highest levels of deprivation in the UK, with highest rates of child poverty before housing costs in the UK (Bradshaw, 2020). Child poverty in the region has increased significantly between 2010 and 2020 when austerity measures have been in place (Vizard et al., 2023). In 2020 Fitzpatrick et al. (2020) found the North East has the highest rates of destitution in the UK, which is defined as people "who cannot afford to buy the absolute essentials that we all need to eat, stay warm and dry, and keep clean" (p.5). This report was published prior to the Covid-19 pandemic, increase in energy prices, and cost of living crisis, all of which will have had an impact on people already living in poverty (JRF, 2023).

Deprivation is a significant driver of demand for children's social care services (Hood et al., 2016) and there is a growing body of evidence linking poverty to child abuse and neglect (Bywaters et al., 2016; Webb et al., 2022). These studies have shown that children living in more deprived communities are more likely to experience abuse and neglect, require additional support, be subject to child protection enquires, and be placed in LA care (Bywaters et al., 2016; Bywaters et al., 2018, Webb et al., 2020).

The North East has the highest rates of referrals to children's social care, and these have increased 77% since 2009 (North East ADCS, 2021). The most recent statistics show that the North East of England has the highest rate of children subject to a Child in Need (CIN) plan, as well as the highest rate of section 47 enquires and Initial Child Protection Conferences (ICPCs) in England (Office for National Statistics, ONS, 2022) The North East also has the highest rate of children who were looked after in the year ending 31st March 2022 (ONS, 2022) as well as the highest rates for children being involved in

care proceedings (Ministry of Justice, 2018 cited in Roe et al., 2021), which includes new born babies (Pattinson et al., 2021). Whilst deprivation and poverty across the region are likely to explain some of the higher rates of involvement with child and family social work services, it cannot alone explain the regional differences (Bywaters, 2017). Areas which have similar levels of deprivation are not showing the same increases, suggesting that there is variation at the LA level in terms of culture and the availability of preventative services (Roe et al., 2021). Northern Ireland has the highest proportion of children living in higher deprivation neighbourhoods in the UK (Bywaters, 2017) yet statutory intervention is less likely there than other regions. Bilson (2017) argues this may be due to “less inequality, stronger communities and a greater emphasis on community based family support services” (p.2) although this requires further research to test their hypothesis. Changes to funding may also explain regional differences. Austerity policies have had a significant impact on the North of England (Beatty and Fothergill, 2014) and LAs in the North East of England were disproportionally affected by the funding cuts related to austerity measures (Hastings et al., 2012). Cuts to budgets are described as, “systematically greater in more deprived local authorities than in more affluent ones” (Hastings et al., 2013, p.3) despite needs within these communities being higher.

The North East of England is a region which has been especially affected by government decisions and the dominance of neoliberal ideology. It has seen the closure of industries leading to higher levels of unemployment and increasing deprivation. Whilst some areas of the region have caught up economically, there remains to be concerns about high levels of poverty and

destitution across the region, which disproportionately impact on the lives of children and families. The North East of England also has the highest levels of statutory social work intervention in the country; which are in part linked to the poverty and deprivation levels, but have also been linked to the impact of austerity measures and reduction in funding and services available. This means there are some distinct challenges for children and families within the region, as well as implications for child and family social work.

2.7. Summary and Conclusions

This chapter has explored the broader social, political, economic and cultural system that child and family social work operates within. It has considered how approaches to child and family social work have changed over time, with various factors influencing the development and continuation of the current child protection paradigm. The dominance of neoliberal ideology has had a profound impact on both child and family social work and the children and families for whom it serves. An increased focus on risk and investigation, coupled with a reduction in the welfare state through austerity policies has added pressure to a system that has seen growing need. Within this there is a culture of blame and risk aversion, coupled with increasingly individualistic views of social problems. This leaves statutory social workers largely left to provide individualised and managerial responses to complex family situations. Within the North East in particular, there have been increases in both referrals and statutory intervention alongside reductions in resources and funding. Questions have been raised about what sets the regional variation seen within the region apart from other areas of the UK, with some debate whether there is a difference in organisational culture that is also driving the variation in

practice. This is pertinent to the topic of this thesis, which explores pre-birth assessment. Arguably pre-birth assessment is the earliest possible opportunity to intervene in a child's life, which has longer term implications for their life trajectory, as well as their parents and wider family's life course. The next chapter of the thesis will explore the current literature and understanding of pre-birth social work practice.

3. Literature Review

3.1. Introduction

This chapter will review the current literature available on pre-birth practice. This aims to answer the question “What is currently known about pre-birth practice in social work?’. Such a broad question was posed to provide a detailed overview of what is currently known and to identify gaps in the knowledge. In order to access as much of the current literature as possible, a systematic approach to searching was used, before the literature was charted to draw out similarities and differences. The literature review explores the reasons pre-birth assessments are undertaken, how often pre-birth assessments are completed, how they are undertaken – considering both guidance and practice issues, what the outcomes are, and what the experiences of professionals and families involved are. Conclusions are then drawn from the current understanding of pre-birth practice with a discussion on how this led to the design of the study outlined in this thesis.

3.2. Planning and conducting the literature review

This section will briefly outline and justify the approach taken to identify, collate and analyse the research for this literature review. The focus of the review is broad in nature and this presented some challenges. A systematic approach was used to identify literature, to ensure a comprehensive overview of the literature was provided and the aims of the review were met. Synthesis and analysis of the data were more iterative in nature and the reasons for this will be explored below.

Initial scoping searches were undertaken to gain an overall understanding of the literature available on pre-birth assessment and associated work. Initial

searches can be useful to help decide the focus of the review question and scope (Victor, 2008). This work began in the summer of 2019 when I was preparing an essay focused on pre-birth assessment, professional identity and ethics, as outlined within the introduction (Chapter 0). These searches identified a diverse but disparate range of literature on pre-birth assessment, including qualitative and quantitative peer reviewed research articles, some literature reviews focused on specific areas of practice, several reports and a small number of PhD theses. The literature available varied in focus and there was no evidence that this had been pulled together to explore what is known about pre-birth assessment in a comprehensive manner.

Due to the small but diverse range of literature identified during initial scoping searches, I decided to complete a very broad literature review, centred around the question, 'What is currently known about pre-birth practice in social work?' Whilst this is a broad question to answer during doctoral study, I felt that it was necessary to fully understand what is currently known, and where there are gaps in the research.

A structured approach to gathering the literature is required in order to ensure all relevant research was identified given the wide-reaching nature of the question. However, the diversity of the literature ruled out a systematic review method. Systematic reviews attempt to synthesise and evaluate evidence based on a very focused question, often focused on a specific population and methodology (Munn et al., 2018; Higgins and Thomas, 2020). As the research identified during initial searches was varied in terms of study methodology and type of literature and focused on a range of populations including practitioners and families, a systematic review would not be possible. Narrative reviews

are often seen as being at the opposite end of the methodological scale to systematic reviews (Efron and Ravid, 2019), and allow the inclusion of a wider range of literature than a systematic review (Gordon, 2018). They have the potential to provide an overall image of a topic by including studies that, “focus on different parts of a single picture” (Hammersley, 2001, p.548). Narrative reviews often do not use clear search strategies (Aveyard, 2014) which Efron and Ravid (2019) highlight can lead to important articles being omitted from literature reviews. Whilst a narrative review methodology would align with the broad nature of the review question, it would not ensure that all relevant literature was included and therefore was not appropriate to this study.

Scoping reviews offer a middle ground between systematic and narrative reviews; with a systematic search strategy being used, whilst allowing the inclusion of a more diverse range of research. Scoping reviews aim to determine the understanding of a given topic (Peters, 2020), and can be especially useful when there is a diverse body of literature (Pham et al., 2014), as was identified during initial searching. Scoping reviews are often undertaken in order to identify gaps in literature and to guide future research (Tricco et al., 2016). For this reason, a scoping review approach to identifying literature was utilised, to identify any relevant literature on pre-birth assessment. Whilst this approach was used for the identification of literature, a narrative approach to the analysis and synthesis of the information was employed. This was a pragmatic decision guided by the confines of academic study and the additional time and complexity that following a scoping review methodology would have added. Ultimately literature reviews serve to situate primary research within the wider research context (Aveyard et al., 2021). By

adopting a systematic approach to literature identification, I was able to ensure that all relevant literature was included but utilising narrative approaches to the analysis and synthesis of the literature allowed more freedom in the collation of the information.

Searches were undertaken across all databases in January 2021, October 2021, March 2022 and November 2022. The initial searches in January 2021 were not limited by date in order to include all possible research from any date range. Subsequent searches were limited to 2021 and 2022 only, to identify any newly published literature. Searches were undertaken across all databases which may be relevant for the topic, including those focused on social sciences and medical professions. This included Assia, Web of Science, SCOPUS, CINAHL, Proquest Social Science Premium Collection, Child Development and Adolescent Studies and Medline. Google Scholar was also used and whilst most of the literature identified through Google Scholar may be duplicated elsewhere, there is evidence that grey literature may be more readily identified by Google Scholar than by academic databases (Haddaway et al., 2015). The following search string was used across the databases:

> (“infant removal” OR “removal at birth” OR “pre-birth assessment” OR "pre birth assessment" OR "prebirth assessment" OR “assessment during pregnancy” OR “prenatal assessment” OR "born into care" OR BIC) AND "social work"

Whilst a structured search is required in a scoping review to evidence rigorous and transparent methods (Munn et al., 2018a) additional search methods can

still be valuable (Arksey and O'Malley, 2005). Even with a well-structured search strategy, additional literature is often identified using supplementary search strategies (Mattioli et al., 2012). This can include both searching the reference lists and citations of relevant literature, and hand searching key journals (Arksey and O'Malley, 2005). Adding these additional strategies complements structured searching and can be justified by the potential to identify additional relevant literature (Aveyard, 2014). After the initial identification of literature using structured searching, hand searching reference lists of articles and citations of the articles was then undertaken.

To be included, articles had to be:

- Written in English
- Conducted within the UK, US, Europe, Canada, New Zealand or Australia
- Focused on pre-birth assessment and/or removal at birth

Research on perinatal loss or voluntary relinquishment were excluded from the review.

Articles were then screened by title and abstract and excluded if they did not meet the inclusion criteria. This resulted in 65 pieces of literature being identified which related to the topic of pre-birth assessment. Once relevant literature was identified this was then 'charted' to extract any relevant information for the research question. The process of charting is providing a descriptive summary of the results by identifying what information may relate to the research question (Ghalibaf et al*.,* 2007), and to identify commonalities,

gaps and themes within the literature (Armstrong et al., 2011). This resulted in five areas of discussion:

- Why do we do pre-birth assessments in social work?
- How often are pre-birth assessments completed?
- How are pre-birth assessments undertaken?
- What are the outcomes of pre-birth assessments?
- What are the experiences of those involved in pre-birth assessments?

The remainder of this chapter will explore the current literature on pre-birth assessment, structured under the questions posed above.

3.3. Why do we do pre-birth assessments in social work?

The reasons for social work involvement pre-birth mirror those for all child and family work (Hart, 2001; Hodson, 2011), including concerns around substance misuse, domestic abuse and violence, parental mental health, and neglect. However, working with unborn babies means that there are some distinctions between pre-birth involvement and other child and family social work. Hart (2001) highlighted that when working with unborn babies, the concept of future parenting makes it distinct to other child protection work as there is “concern because of 'who they are', not because something specific has happened to the baby” (p.82). This means that there is a greater focus on the parents and their own characteristics or behaviours when justifying involvement before birth. It is of note that much of the research in this area focuses on the removal of infants from their parents shortly after birth, rather than pre-birth assessment as a whole. This may skew the findings towards examples where removal of an infant has taken place.

First, I will consider the literature on pre-birth more holistically, which has been explored in England by Hart (2001), Hodson (2011) and Critchley (2018b), and in Australia by Meiksans et al. (2021) and Taplin (2017). All five of these studies looked at case files where referrals had been made regarding unborn babies over a set period of time. Hart (2001) considered only instances where there was a child protection plan in place for an unborn baby, Hodson (2011) included unborn babies who had received an initial assessment (IA), and Meiksans et al. (2021) and Taplin (2017) included referrals for unborn babies, regardless of the outcome. Hart's (2001) and Hodson's (2011) studies represent the most up-to-date research in England that encompasses outcomes broader than removal of a child.

Hart (2001) found that the infants who were on a child protection plan before birth had concerns about parental mental illness, learning disabilities or substance misuse. Most of the sample cases also noted violence or partners who were not consistently present or supportive. Just under half of the sample had also had previous children removed from their care. Similarly, Hodson's (2011) research identified initial assessments being undertaken due to concerns of substance abuse and domestic violence in most cases, as well as previous concerns about older siblings. It is notable that Hodson (2011) only looked at 10 assessments in her sample as this was a small part of her study. Whilst Critchley (2018b) did not explore the reasons for social work involvement with families in any depth, she explained that within her sample reasons for included physical health issues, mental health difficulties, domestic abuse, substance misuse, homelessness and suspected learning difficulties. This was based on her sample of 12 unborn babies. Meiksans et

al.'s. (2021) work in Australia drew on the PhD research by one of the authors (Flaherty, 2021) and used case file review of a random sample of child protection reports on unborn children in a year in one Australian jurisdiction. The most common factor for involvement was domestic violence and abuse, which was present in almost 70% of the reports. This was closely followed by parental substance misuse and parental mental illness, with fewer than half of the instances of parental mental illness diagnosed and only suspected. Parental criminal activity was also cited as a reason for involvement in around one-third of the cases. Historical concerns regarding child abuse in the family, either for the parents or siblings of the child was also a factor for involvement with over 90% of the cases including a sibling who had been subject to child protection proceedings and a quarter where a sibling had been subject to a care order. Taplin et al. (2017) looked at the characteristics of women referred to child protection in one jurisdiction of Australia. The largest proportion of their findings were attributed to 'future risk concern', but the nature of this risk was not reported. They also found concerns about domestic abuse and violence, neglect, mental illness, and substance misuse.

The remainder of the research focuses on reasons for removal or progression to care proceedings rather than involvement with families on a broader level, with studies from the UK, mainland Europe, Australia and Canada. The first study which considered reasons for pre-birth involvement that resulted in the removal of an infant from their parents was published by Fairburn and Tredinnick (1980) in England. It was based on self-reporting by LAs and only 61% of the LAs returned information, resulting in the authors analysing 144 instances of removal. They found that the reason for removal included parental

mental illness, learning disabilities, and concerns about previous child abuse. Fairburn and Tredinnick (1980) were surprised that there were some first-born babies removed from their parents and questioned this practice: “We had… wrongly assumed that psychotic illness or severe mental handicap only would justify removal of first-born children” (p.991). They found other reasons justifying the decision included mental illness, learning disabilities, misusing substances, and lifestyles which included mothers being single, unstable, homeless, or involved in prostitution. Whilst some of these factors, such as mothers being single, may no longer be relevant contributors to involvement with families before birth, many of the other factors continue to be highlighted in more up-to-date research.

More recent research into court proceedings has identified similar reasons for intervention. Kurtzinna and Skivenes (2021) and Luhamaa et al. (2021) looked at instances of unborn children who had been subject to court proceedings across a range of European countries, including England. The most common reason for involvement in both studies was parental mental illness. Parental substance misuse was the second most common reason, and then learning disabilities. Luhamaa et al.’s (2021) study also commented on the number of risk factors mentioned, with just over half of all judgements only mentioning one, just under a quarter mentioning two and roughly five percent mentioning three. Juhasz (2020) and Wall-Wieler et al. (2018a) explored instances of first-born removals, in Norway and Canada respectively. They identified the same risk factors already outlined, although Wall-Wieler et al. (2018a) found that the most frequent predictor of removal following birth was the mother being in care herself, which may be a differentiation between first born removals and

subsequent removals. Senevirante et al. (2003) looked at families referred for assessment into a psychiatric Mother and Baby Unit in England. Given the population of this study, it is unsurprising that mental health issues were the most identified factor which led to the mother and baby being placed in the unit. The authors also identified that there were higher levels of concern raised regarding mothers who had an older child.

Whilst the research on reasons for involvement with families before birth is limited, studies on care proceedings can also offer some insight into the risk factors present within pre-birth social work. It is important to note studies on care proceedings often only consider the final judgments made in court, and the original reason for involvement cannot always be deducted. The current and most recent literature is skewed towards the most severe levels of intervention. There are more studies exploring care proceedings and child protection, but no studies exploring child in need cases and instances where no social work involvement was required following assessment. This is a gap in the literature which could be explored further. What is clear across the studies is that there is usually more than one reason for involvement, with families presenting multiple risk factors (Flaherty, 2021; Juhasz, 2020; Kurtzinna and Skivenes, 2021; Luhamaa et al., 2021; Meiksans et al., 2021), evidencing the complex nature of pre-birth social work. What is also key from the literature is that many of the risk factors could be mitigated with appropriate access to services (Wall-Wieler et al., 2018a). There is some research which explores different ways of supporting families during pregnancy and this will be considered later within this review (see 3.7).

3.4. How often are pre-birth assessments completed?

The data on how many pre-birth assessments are undertaken by LAs is not collated (Mason and Broadhurst, 2020) so the full scale of pre-birth assessment work is not known. While Hart (2010) argued that "pre-birth assessments are not routine and usually reflect a high degree of concern about the risk of significant harm to the unborn child" (p.229), five years later Mason and Dickens (2015) argued that "a substantial proportion of child protection work relates to unborn or newborn babies" (p.109) based on the number of unborn babies subject to child protection plan at the time of writing (900 in 2013), and research on care proceedings related to infants, which will be explored further within this section. As of March 2022, there were 1330 unborn babies on child protection plans in England (DfE, 2022).

Unborn babies on child protection plans only represent a proportion of the pre-birth assessment work that social workers undertake, with those who are not considered to be at risk of significant harm not being counted in these figures. The statistics on 'Child in Need' plans can also offer insight into the number of assessments undertaken. As of March 31st 2022, there were 7300 unborn children on Child in Need plans, representing 1.8% of all children (DfE, 2022). Whilst these statistics show some indication of the scale of pre-birth assessment, this still does not represent a full picture, as it fails to recognise pre-birth assessments which have ended without the need for any additional support or intervention, or those which have subsequently been referred to services outside of social work. Mason and Broadhurst (2020) argue that we should collect information on how many pre-birth assessments are undertaken to better understand this area of practice. This would allow a more

comprehensive understanding of what proportion of child and family social work is started before birth.

What is clear within the literature is that there is a rising number of children being removed shortly after birth or being born into care (BIC) as it is often referred to. This pattern is clear within the UK (Alrouh, et al.; 2020; Bilson and Bywaters, 2020; Broadhurst et al; 2013; 2014; 2018; Broadhurst and Mason, 2020; Pearson et al., 2020; Raab et al., 2020) as well as other western countries such as Australia, and across Europe (Harrison and O'Callaghan 2014, Harrison et al., 2020; Hestbæk et al., 2020). Whilst the number of infants BIC is rising across the western world, other countries, apart from the USA have a lower rate of infants being BIC than the UK (Pearson et al., 2020). Several authors have raised concerns that these changes paint a very worrying picture of increasing statutory intervention in families lives (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Pearson et al., 2020). This topic has been the focus of significant Nuffield Family Justice Observatory (NFJO) research since 2018 (Mason and Broadhurst, 2020). Research by Broadhurst and colleagues has highlighted previously unexplored issues around this growing area of practice within the UK, using CAFCASS data to explore the rates of infants BIC, which is defined as entering Local Authority (LA) care within the first year of their life (Broadhurst et al., 2018).

Despite the separation of infants from their parents being described as 'draconian' by the courts (Mason and Dickens, 2015), and a view that it should only be undertaken for "extraordinarily compelling reasons" (Council of Europe, 2015, n.p), the number of infants BIC is continuing to rise. Broadhurst et al. (2018) report a rise in the volume of care proceedings for infants in

England, as well as the proportion of court applications for care orders that infants BIC represent. Between 2007 and 2017, court applications for infants more than doubled from 1039 to 2447. The proportion of cases relating to infants representing 32% of care proceedings in 2007 and 42% in 2017. The likelihood of newborn babies being subject to care proceedings also more than doubled across the study period, from 15 per 10,000 live births to 35 per 10,000 live births. Mason and Broadhurst (2020) hypothesised that criticisms of the use of section 20 in case law may have contributed to the rising number of care proceedings. Section 20 of the Children Act 1989 involves children being placed into care voluntarily with parents' agreement (Brammer, 2020). However, Bilson and Bywaters (2020) found that the rates of infants being born into care were 44% higher in England that those by Broadhurst et al. (2015, 2018) when removals under section 20 were also included within the data. This suggests rises may be higher than expected and Mason and Broadhurst's (2020) hypothesis that the rise may be partly explained to reductions in the use of section 20 is not correct. This finding was also supported by Pearson et al. (2020) who found that more than half of infants enter care under section 20.

Similar rises have been found in other areas of the United Kingdom. Between 2011-2018 Alrouh et al. (2019) found that infants aged less than one year old constituted 30% of the total number of children entering care in Wales. In addition to this, the number of infants entering care over the study period increased by 68%. The incidence rate for infants BIC has been consistently higher in Wales than it has in England, but as with England this has been increasing. There has been an increase from 53 babies per 10,000 live births

in 2011 to 96 babies per 10,000 live births in 2018 (Alrouh et al., 2019). Similar increases in the number of infants being BIC are evident in Scotland (Raab et al., 2020). The reasons for these rises are unclear but may be attributed to cuts in LA spending on support services and pivotal reports following high profile deaths of children (Pearson et al., 2020). Broadhurst et al. (2018) also questioned whether increasing financial hardship and risk averse culture have had an impact on the increases. In England, there is also marked variation between LAs in the number of infants BIC with Broadhurst and Mason (2020) profoundly concluding that, “infants do not have an equal chance of being born into care” (p.13) in England, and that this depends on where they are born, and what services are available within the LA. This will be explored further within section 3.8.

There is increasing awareness about the likelihood of further removals from a mother who has already had an infant removed. Alrouh et al. (2020) found that one in four mothers were at risk of appearing in more than one set of proceedings during the eight years of their study. The average time between proceedings was 17 months, which allowed little opportunity to evidence change (Alrouh et al., 2020). Similar timescales have been identified in England (Broadhurst et al., 2014; Broadhurst et al., 2018). Whilst there is an increased risk of subsequent proceedings, Alrouh et al. (2020) found that this decreased dramatically if there had not been another birth within the first three years after removal. What is evident in the literature is that women are likely to go on to have another baby, and possibly face further proceedings, if there is no additional support offered following removal. The support available to families and the effectiveness of this will be discussed in section 3.7.5.

Whilst data on the numbers of pre-birth assessments is not collected, it is clear from the literature that assessment and intervention before birth is increasing across the western world. There appears to have been a shift, from pre-birth intervention only being used in exceptional circumstances (Hart, 2010) to it becoming something that child and family social workers are often involved in. This raises questions about how the work is approached, the focus of the next section.

3.5. How are pre-birth assessments undertaken?

This section explores how social workers approach pre-birth assessment and what legislation, guidance and policy support this work. The application of legislation and availability of national guidance is very limited, and local guidance and processes differ greatly across the English LAs. Within this section the discussion on legislation and guidance will be limited to the UK, however, practice literature from other western countries will be considered on decision-making and ways of working with families as the process of social work involvement is comparable within the Western world. Following the exploration of guidance, how social workers approach the work and some of the challenges associated with it will be considered. These include structuring the assessment, timing, developing relationships and decision-making. There is growing area of literature on the importance of support for families after removal and the learning from these studies will be explored before concluding this section.

3.6. Guidance and legislation

Pre-birth assessment was first mentioned in English national guidance in the first version of WTSC which was published in 1991 (Hart, 2001). Since this

time, the focus on pre-birth assessment in legislation and guidance has not increased in line with the growth in this area outlined previously (see section 3.4). At the present time, statutory guidance for pre-birth assessment and initiating care proceedings at birth is lacking (Broadhurst et al., 2018). One of the challenges for applying legislation to unborn children relates to the legal status of the foetus and socially constructed understandings of childhood. Baker (1997) captured this well, stating:

> "For those working in the field of child protection and unborn children there are areas of both clarity and confusion. The law may, in some areas of its domain, be clear that childhood starts at birth. The state, in the form of the guidance it delivers to local authorities, is also clear that for the purposes of child protection the foetus should be treated as if it were a child." (p.227)

Whilst Baker's research is now 25 years old it remains relevant as more recent research evaluating national legislation, policy and guidance have drawn similar conclusions.

In England, social work involvement with children and families is underpinned by the Children Act 1989 and assessments or enquires with families may be undertaken under section 17 or section 47. Assessment may be based on consent from families under section 17 which places a duty on LAs to "to safeguard and promote the welfare of children within their area who are in need" (Children Act 1989, 17(1)). Statutory involvement without consent may also be undertaken should the LA "have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer,

significant harm" (Children Act 1989, 47(1)). The legislation does not specify that this is applicable to unborn babies, but the statutory guidance WTSC (HM Government, 2018) states that child protection processes can apply to unborn babies. In her exploration of national guidance, Hodson (2011) found that WTSC (HM Government, 2006) made very few references to social work regarding unborn children, only explaining that what would apply to a child would also apply to an unborn infant. Hodson (2011) highlighted that this raised ethical and practice tensions:

> "The anomalies and ambiguities this creates in relation to the legal rights of the mother and the lack of rights of the unborn child were not explained, explored or addressed within either the statutory requirements or non-statutory practice guidance making up the document." (p.81)

Revisiting the most recent version of WTSC (HM Government, 2018), there are still few mentions of pre-birth assessment or work with unborn children, although it does state that the LA should produce a protocol for the assessment of unborn children and that child protection processes can apply to unborn children. Currently, there is no national guidance that sets out the expectations of professionals involved in assessing unborn babies and their families (Mason et al., 2022a).

The lack of national legislation, policy and guidance has resulted in variations in local policy and guidance across the UK. In 2011 Hodson found that 90% of Local Safeguarding Children's Boards (LSCBs) made reference to pre-birth assessments within their procedures; however, the content of this guidance

was varied and predominantly procedural in nature. Of the LSCBs which did make reference only 64% of them had information in addition to that contained within WTSC (HM Government, 2006). This information again varied in length and quality, from a few paragraphs to several pages which outlined guidance on aspects such as early identification and assessment, levels of risk and pre-birth strategy or planning meeting (Hodson, 2011). Hodson's (2011) research was updated by that of Lushey et al. (2017) who examined the pre-birth guidance for all LSCBs within England. By this time all LSCBs referred to pre-birth assessments within their procedures and 96% provided information in addition to that contained within WTSC (HM Government, 2013). Lushey et al. (2017) did not comment on the quality of the individual guidance given in LAs, although they did conclude that that there was a "lack of detailed guidance for pre-birth assessment" (pp.104-105).

The literature suggests there is variation across LAs in England in the timings for referral and starting assessments, and the point at which formal meetings should be held. Baker (1997) noted, "The question regarding at what point in the pregnancy child protection procedures should be invoked to consider the foetus is a complex one*"* (p.223) as there is a need to balance the impact on the mother with protecting the infant which can lead to an ethical debate. Twenty-five years ago, on reviewing the role of pre-birth assessments Baker (1997) stated that there are "powerful arguments for early involvement in relation to unborn children" (p.223) but went on to explain the difficulties of balancing this with the mother's right to seek a termination. This question about timing and concerns about pressure on parents to seek a termination continues in more contemporary literature (Mason and Dickens, 2015) with

worries that early intervention may impact the mother's views on seeking a termination (Calder, 2000). Calder (2013) went so far as to suggest that pre-conception assessments should be undertaken to allow parents to make an informed choice about pregnancy, but the reality of workloads within child and family social work would make this difficult to justify.

The question of when to initiate work with families during pregnancy has continued in more recent literature. In her examination of LSCB literature, Hodson (2011) found that only two of the 73 LSCBs she examined had specific timescales for referrals of unborn children, one stating by 18 weeks and the other at 20 weeks' gestation. In their update of Hodson's (2011) work, Lushey et al. (2017) did not comment on the specific timescales set by LSCBs but commented that "the level of detail with regards to timescales varied" (p.101). In the Scottish context Critchley (2018b) found that whilst many families were notified of the referral to Children's Social Care at 10 weeks' gestation, often they waited until after 20 weeks' gestation for an assessment to begin. This was the case even when a social worker was already allocated to the family due to involvement with other children. One of the reasons given for this delay was about it being better practice to wait until the pregnancy is established, and the mother being past the timescales for a legal abortion, as has been mentioned previously. Similar suggestions were made by the social workers in Lushey et al.'s. (2017) study, with social workers suggesting that pre-birth assessments wait until the pregnancy is deemed as viable. Prior to these studies, other studies have also found that pre-birth assessments are delayed until the later stages of pregnancy, or even until after the birth of the child (Calder, 2003; Hart, 2010, Hodson, 2022; Ofsted, 2011).

Hodson (2011) identified variation within LSCB guidance regarding the timescales for an Initial Child Protection Conference (ICPC) regarding an unborn baby, with guidance suggesting times from before 28 weeks' up to 34 weeks' gestation. In their exploration of subsequent pre-birth assessments, Broadhurst et al. (2017) have built on Hodson's (2011) work. They found significant variation between the timings for ICPCs, both in terms of practice and guidance issued by LAs; 32% were held between 8 and 4 weeks before the birth, 24% between 4 weeks and the birth, and 6% after the birth. In terms of guidance, many LAs recommended that ICPCs should be held between 18-20 weeks' gestation, but some recommended that they should be held as late as 32 weeks' gestation (Broadhurst et al., 2017). Despite the debates around processes, Hart (2001) found that it was proactive planning, rather than the child protection process itself, that made a difference to the outcome of pre-birth assessments. This suggests that it is how work is undertaken, rather than processes and timescales, that make a difference.

Mason and Broadhurst (2020) completed a series of workshops with professionals from 57 LAs across England. There was acknowledgement by professionals that the timing of assessments and work with families varied greatly. Late intervention was not attributed to a lack of awareness, but instead a lack of resources because of ten years of austerity and cuts to services.

At the present time, guidance on pre-birth assessment and best practice regarding care proceedings at birth is very scant (Broadhurst et al., 2018) and requires attention from policy makers (Critchley, 2018b; Lushey et al., 2017). The next section will build on what impact this has on practice.

3.7. Practice with families during and following pregnancy

The lack of guidance available for pre-birth work has filtered down into practice, resulting in variations in the way assessments are undertaken, and the work that is done with families during pregnancy. There are concerns about how assessments are undertaken and the focus during the work, how social workers learn to undertake pre-work and how assessment and intervention are balanced in practice. Some research has been completed to try and standardise practice, but the resulting frameworks are not widely used, and their efficacy is questioned. More recently, research has been undertaken exploring more structured approaches to pre-birth work which have shown some promise, but this work is in its infancy. This section will explore the current research on how social workers structure their assessment and intervention work. Due to the wide scope of this section, this has been broken down into several different areas. These are 'the structure of assessments', 'the focus of the work', 'The importance of relationships', 'Decision making', and 'Post-removal work'.

3.7.1. The structure of assessments

There have been concerns raised about the quality of pre-birth assessments and the consistency both between LAs and within LAs. During her six-month audit of one LA's pre-birth assessment cases, Hodson (2011) found the assessment process to be "haphazard and complex" (p.156) with the quality of assessments varying greatly and some not being completed. Ward et al. (2010) drew similar conclusions when they looked at very young children, which included unborn babies. They found the quality of information on many assessments was inadequate. No recent studies have evaluated the quality of

pre-birth assessments, so it is unknown whether this has improved over time. Hodson (2011) found that social workers tended to structure their assessments differently and did not use any guiding literature or framework, which led to social workers deciding individually what was important to consider during the assessment. This was linked to how they 'learned' to do pre-birth work, which was often "based on implicit knowledge and practice wisdom developed in relation to post-birth assessment work with children and families." (Hodson, 2011, p.253). Social workers learned to do pre-birth assessments by speaking to colleagues with experience and their practice was shaped by the attitudes, knowledge, and approaches of these more experienced workers. Seven years later, in their interviews of 22 practitioners from nine LSCB areas, Lushey et al. (2017) found that some practitioners reported not knowing how to undertake pre-birth assessments. In the absence of guidance, they turned to colleague for advice. One participant stated, "it can feel a little bit like swimming through treacle really. Where do you start, what things do I need to take account of? How do I even structure the assessment?" (Lushey et al., 2017, p.102). Training and learning around how to undertake pre-birth work has been identified as a gap in practice and research (Hodson, 2011; Lushey et al., 2017; Mason et al., 2019; Mc Elhinney et al., 2019). The current suggestion that this is based on experiential and informal learning raises concerns in light of organisational culture, risk averse practice, and significant variations in the outcomes of pre-birth work which are all explored later within this review. This study aims to explore aspects of 'learning' pre-birth practice and add to the current knowledge base on this topic.

Social workers in Hodson's (2011) study felt that the Framework for Assessment (Department of Health, 2001) did not fit with the pre-birth assessment task, which led to them creating their own assessment proformas. More recently Lushey et al. (2017) identified similar issues which led to social workers developing their own way of structuring assessments from a "pre-birth angle" (p.104). Lushey et al. (2017) raised concerns that this could lead to key information being missed during assessment. There have been attempts to develop guidelines for pre-birth assessment work which make more clear links to unborn babies, including Corner's (1997) tool and Calder's (2000, 2003, 2013) pre-birth assessment tools. Calder (2013) reports that his pre-birth assessment tool has been widely adopted by LAs across the UK however Lushey et al. (2017) reported that this was not the case at the time of their study. Whilst the Corner (1997) and Calder (2000, 2003, 2013) tools went some way to try and provide more standardised practice and make more distinct links between the assessment task and unborn babies' needs, there have been no studies which have assessed their efficacy (Mc Elhinney, 2019) and they may now require updating (Lushey et al., 2017).

In addition to the frameworks which have been developed, there are some emerging assessment and engagement strategies which have shown promise in pre-birth social work. One of these is the Ox-PuP pathways trial being undertaken in Oxfordshire (Barlow et al., 2016; Harnett et al. 2018). The model is based on the Parents under Pressure treatment model, which is an Australian parenting programme (Parents Under Pressure, 2022). The model involves detailed assessment including standardised measures, frequent visits to the family by social workers and family support workers, iterative and clear

objective goal setting, and individualised therapeutic intervention which starts before birth and continues after birth (Barlow et al., 2016). Initial feedback from both professionals and family on the pathway has been positive. Harnett et al. (2018) compared pregnant women allocated to the specialist pre-birth programme and those receiving standard pre-birth assessment and intervention and found better outcomes for mothers and lower rates of child protection outcomes for the specialist pathway when compared to standard pre-birth practice. Shaw (2021) also found promise in using the Family Drug and Alcohol Court (FDAC) with wider populations of pregnant mothers, rather than just those using alcohol and substances.

3.7.2. The focus of the work

The focus of assessment and intervention during the pre-birth period is another area which requires attention, with Mason and Broadhurst (2020) finding that some social workers were primarily focused on assessment rather than offering intervention and support to families. This was due to both cuts to services and a lack of resources and also social workers confidence in offering services. Some LAs, including London LAs had more services available (Mason and Broadhurst, 2020) which may be linked to higher success rates for infants remaining with their families following birth. This is explored further within section 3.8 and the implications of this will be discussed. The focus on services was also explored by Luhamaa et al. (2021) who reviewed support for mothers and newborn babies across eight European jurisdictions including England, using court judgements on infants who were removed within 30 days of birth. Services were mentioned in almost all the English judgements however these services were often focused on parental problems, which links

back to the reason for undertaking pre-birth assessments (see section 3.3). Luhamaa et al. (2021) hypothesise that this may be due to the risk-orientated child protection system in place in England and the authors raise concerns about the focus on parents' individual traits and issues, when there is limited research evaluating the adequacy of services that parents are offered. This is especially worrying given concerns about delays in services, and variation of services offered across the country, explored elsewhere in this review (see section 3.8).

Timing in terms of policy and legislation has already been explored but the literature also suggests wide variation on an individual practice level, with the timing and day to day practice varying between individual social workers (Hodson, 2011). There is some evidence to suggest that pre-birth assessment is seen as less urgent, or as a lower priority than work with children after birth. Hart (2001) found distinct variation in timing for assessments across the LA that she studied and that this was based on the individual allocated social worker's decision. She commented that some took a "tentative 'wait and see' approach" (p.81) whereas others proactively started a pre-birth assessment on allocation (Hart, 2001). The approach of 'waiting and seeing' could even happen in families where social workers were involved with siblings. Seventeen years later, Critchley (2018b) found similar variation in practice, with families often being informed of referrals at ten weeks of gestation, but social workers not starting their assessments until 20 weeks' gestation or later. As with Hart's (2001) study, this could be the case even when the unborn babies' siblings were open to social workers. In both studies, the decision to delay involvement was partly linked to waiting until the pregnancy was viable,

as discussed, but Critchley (2018b) also identified decisions being resource driven, with a difficulty to prioritise unborn babies over living children on the social workers' caseloads. Lushey et al. (2017) and Broadhurst et al. (2022) reported similar findings, with work with unborn babies and their families being seen as less urgent than work with children after birth, and difficult to prioritise in the face of more immediate crises. Hodson (2011) highlighted that pre-birth assessments are often undertaken by social workers holding large and complex caseloads, and this could explain some of the delays in social worker prioritising pre-birth assessments. Critchley (2018b) also suggested there was individual flexibility on what was undertaken once the family were allocated to a social worker, with one participant expressing a view that others thought there was no real role for him until the baby was born, but he felt that he should take a more proactive role as he felt "there's a chance this could work" (Critchley, 2018b, p.221). This links back to the differences in structure and work that is undertaken with families, and how social workers see their role during pre-birth assessment.

These issues with timing may ultimately have an impact on the outcome of assessments. Broadhurst and Mason (2013) argue that delaying pre-birth assessment does not give parents time to evidence change. As outlined previously, the circumstances where pre-birth assessments are required often involve complex situations and multiple levels of needs and risks within families (Flaherty, 2021; Juhasz, 2020; Kurtzinna and Skivenes, 2021; Luhamaa et al., 2021; Meiksans et al., 2021; Phillip et al., 2020). Delayed assessments, whether this is due to LA procedures or individual practice, mean that families have less time to access support, and therefore less time

to evidence that there has been sufficient change in the situation which would allow the baby to remain safe in their care (Critchley, 2018b; Ward et al., 2010). The limited time available to social workers and families can have a detrimental effect on working relationships between them. Relationships are seen to be key in effective pre-birth practice (Critchley, 2018a; 2018b), which will be explored later in section 3.7.3. Having limited time to form an effective working relationship which can support change within families is a significant barrier to pre-birth practice (Critchley, 2018b, 2020a; Lushey et al., 2017) as time is required to build relationships and trust with families, especially those who may be reluctant to engage (Lushey et al., 2017). The time to evidence change can be especially challenging in recurrent proceedings, with evidence to suggest the average timescales between proceedings is only 17 months (Broadhurst et al, 2015; Alrouh et al., 2020) and subsequent proceedings often being shorter (Broadhurst et al., 2014), leaving little time to support and evidence change with the families.

Parents in Critchley's (2018b) research felt that earlier involvement would be more beneficial as otherwise the decisions were "'hanging over' the pregnancy" (p.121). This late intervention can mean that high demands are placed on parents in the final stages of pregnancy, which can feel overwhelming and have a negative impact on the parents' wellbeing (Critchley, 2018b). The demands placed on parents to attend a high volume of appointments whilst balancing other aspects of their life could result in missed appointments (Broadhurst, 2017) which may then be used against them in child protection and court processes. This focus on attending appointments and 'compliance' is explored further later in the review (see section 3.7.4).

3.7.3. The importance of relationships

Relationships between professionals and families has been highlighted as key to effecting change and ensuring that babies can remain in their parents' care following birth (Broadhurst et al., 2017; Critchley, 2018b; 2019; Harrison and O'Callaghan, 2014; Hart, 2001; Lushey et al., 2017; Mc Elhinney et al, 2019). Whilst developing professional relationships is important in all social work there are some additional barriers to this in pre-birth practice. Parents who have experienced previous removals may have a pre-determined view of involvement with social workers and worry that it will result in a negative outcome for them (Calder, 2000) and this mistrust in workers has been cited as a significant barrier to effective working relationships (Cox et al., 2017).

Relationships within pre-birth practice need to be established early as the timeframe is often short, as explored earlier in this review. The first barrier to this can be understanding the purpose of involvement when there is no baby present (Critchley, 2018b). Hart (2001) questioned whether all the parents in her study fully comprehended the potential outcomes of the assessment and the serious nature of pre-birth work. Similarly, Critchley (2018b) found that parents did not always understand the purpose of assessment and intervention before birth and that this can mean families are not fully aware of the nature of the concerns and potential outcomes (Ward et al., 2010). Trew et al. (2022) found that most parents had a basic understanding of why social workers were involved but that they lacked detained information and reported a lack of communication from professionals which contributed to their levels of stress. Parents in Marsh et al.'s (2019) study reported that they would have been more motivated to address the concerns and work with professionals if

they had clearly been told the concerns during the pre-birth assessment. There is some evidence that being honest and open about the purpose and the scope of the assessment early in the work can develop more positive relationships and make parents more likely to engage (Cox et al., 2017; Hart, 2001; Lushey et al., 2017; Ward et al., 2010).

One of the main reasons for undertaking a pre-birth assessment is when previous children have been removed from a parent's care (Broadhurst et al., 2018) and Ward et al. (2010) found that parents relationships with practitioners "were often coloured by past experiences" (p.242). Resistance to engage is often cited by professionals during pre-birth assessments (Broadhurst et al., 2017) yet it is understandable that parents may show some resistance in engaging in a process which may result in the removal of their newborn babies. From a family perspective, Broadhurst and Mason (2020a) found that families feel as if the past risks dominate future decisions about their babies. Similarly, parents in Trew et al.'s (2022) study in Australia believed that professionals were more focused on past concerns, with limited recognition of the changes they had made since then. Families can feel pre-judged as a result of the involvement, and sensitivity and understanding of trauma-informed practice are needed when faced with this resistance (Broadhurst et al., 2017). Developing these relationships requires sensitivity and patience from professionals whilst recognising why engagement may be difficult (Shaw, 2021) as well as openness and honesty (Lushey et al., 2017; Mc Elhinney et al., 2021). Ward et al. (2010) found that parents valued straight-talking social workers who "did not 'beat around the bush'" (p.222) over overly optimistic

social workers who found it harder to share bad news. They perceived honest social workers as nicer, easier to work with and more trustworthy.

Relationships with fathers and wider family have also been highlighted as a gap in practice. Critchley (2018b) found that fathers were not always visible in the pre-birth process and tended to come in and out of view, which has also been identified as an issue by Phillip et al. (2020) and Hodson (2011). Practitioners in Critchley's (2018b) study tended to have low expectations of fathers and the working relationships were not as strong with fathers as with mothers. Critchley (2018b) and Hart (2001) both found fathers more likely to be mentioned if they are perceived as a risk. Hart (2001) found that wider family members, especially grandparents, were more likely to be involved in the assessment process, but this appeared to be because they had put themselves forward rather than being invited. This lack of focus on fathers and wider family increases the gaze on mothers and heightens the expectations on her. Critchley (2018b) argues that this increases the vulnerability of the unborn baby. Whilst the lack of focus on fathers is not isolated to pre-birth practice, it is an area which appears to require further development.

3.7.4. Decision making

The decision of whether a child remains with their parents after birth is a huge responsibility (Critchley, 2018b). Whilst making decisions about all children's care is challenging, given the ethical challenges of pre-birth practice and the fact that most infants removed after birth will not return home (Bilson and Bywaters, 2020; Pearson et al., 2020), there are additional complexities in pre-birth decision making. These questions have been raised since the first piece of research considered pre-birth assessment, yet 42 years later it appears the

questions remain the same. Fairburn and Tredinnick (1980) questioned, “How may the ability of the parents be assessed in young and inexperienced people with no child to handle? With what accuracy can one extrapolate disturbed and damaging behaviour towards an earlier child to that with subsequent babies?” (p.990). There remains a lack of research on decision making within pre-birth assessment and given the lifelong consequences that these judgements can have, this is a gap in knowledge (Harrison and O’Callaghan, 2014). This section considers the current knowledge on decision making and highlights themes that are present in the literature including compliance, subjectivity and risk aversion.

One area which has emerged as prominent in recent literature is the apparent weight that engagement by parents is given, in the decision-making process. Luhamaa et al. (2021) found that an emphasis was placed on parental cooperation with social services and the courts across all countries in their study. In England it was mentioned in 93% of the judgements, with 71% of those points being negative. This focus has also been identified in case files. Hart (2001) found assessments often focused more on the interactions between the mother and the social worker rather than the facts of the situation, with parents' response to social workers appearing key in decision making. Hart (2001) and Critchley (2018b) have questioned this conflation of cooperation with the assessment of parenting capacity. Critchley (2018b) called for recognition that engagement with child protection processes during pregnancy is difficult and that social workers have a duty to challenge the system, rather than using this as a means of evidencing poor parenting capacity. Hodson (2011) also noted cooperation being mentioned as a feature

within the case files she reviewed although conversely, she did not find that this ultimately impacted on the outcome of the assessment. As with Hart (2001), she found that it was often parent's compliance which was commented on more than parenting capacity, hypothesising that this may be easier to measure.

Many parents in Critchley's (2018b) study felt that engagement with social workers was the only way that they could evidence to professionals that their baby would be safe with them following birth. Similarly in Marsh et al.'s (2019) study, some parents worry that if they do not agree with social workers that would go against them and that they would be labelled as "difficult and uncooperative" (p.e9). Despite this, other parents in Critchley's (2018b) study openly use resistance as a strategy to deal with the threat they felt social workers posed, but this served to make social workers "distrustful and suspicious" (p.174) of them evidencing the role cooperation plays in the assessment process.

Legally, engagement during the pre-birth period is voluntary for parents, and it is unsurprising that they might not wish to engage in an assessment, as outlined in section 3.7.2. Families might also find it challenging to engage with such a wide range of services whilst having complex needs of their own (Meiksans et al., 2021). McGory et al. (2019) found the increased scrutiny that women experience during pre-birth assessment may lead to increased avoidance which is then interpreted as non-compliance. Hart (2001) related the focus on cooperation back to the importance of relationships during prebirth assessment, stating, "in order to have a choice as to their level of cooperation, parents must first know what the rules are: what it is they are

being asked to cooperate with." (p.175), again highlighting the role of honesty within the relationships.

Whilst literature suggests a heavy focus on compliance in pre-birth work, in their longitudinal study of very young children at risk of significant harm Ward et al. (2010) found that the cooperation of parents was a "misleading indicator in that it gave no real evidence of a parent's desire or ability to change" (p.156). They came to this conclusion after reviewing the long-term outcomes for the children in the study. Ward et al. (2010) found that it was the impact of the services in evidencing change, rather than just engagement that was key to positive outcomes.

Subjectivity is another factor that influences decision making. Whilst all assessments in social work inevitably contain some level of subjectivity, Hart (2001) argues, "[pre-birth assessments] are perhaps more subjective than most because there are crucial elements of the usual story missing: there is no abused child to observe, examine or interview, and the relationship between parent and child is invisible" (p.143). Subjectivity appears to be present from the referral throughout the pre-birth assessment process (Hodson, 2011). Judgement is difficult and relies on social workers to interpret what they see (Hart, 2001; Hodson, 2011) which can lead to different social workers reaching different conclusions about the same information (Hodson, 2011). Given that the view of the social worker may be seen as more important than the evidence and facts of the case (Hart, 2001), this subjectivity can heavily influence the outcome of any assessment. Critchley (2018b) and Hodson (2011) have questioned how the stories of families could be reframed from a different perspective which might impact the outcome of the

assessment. This focus on perception and judgement was also highlighted by Ondersma et al. (2001) who explored social work responses to pre-natal substance misuse in the USA and found significant variation in decision making between teams and states. Interestingly, most of the respondents felt that their county's response was appropriate, suggesting that decisions are made using subjective practice and cultural norms within individual organisations, rather than research and more standardised assessments of risk. Hart (2001) also identified the influence of culture in terms of "organisational imperatives and implicit assumptions" (p.141) being made in assessment and went on to argue that given the high stakes of decisions regarding unborn babies, this practice needs to be exposed to further scrutiny and reflection if it is to be improved.

Identifying the risks for potential harm to an unborn baby is a challenging aspect of the professional role (Mc Elhinney et al., 2019). There is a small but consistent evidence base suggesting that practitioners are more likely to take a risk averse stance. Risk averse practice is a topic which has received a great deal of attention within child protection social work over recent decades (Hardy, 2020). Both Hart (2001) and Critchley (2020a) have concerns about the current climate of child protection social work and the impact that this has on outcomes for newborn babies and their families, with these conclusions spanning two decades of practice. Hart (2001) explained how the perceived accountability and scrutiny of child protection social workers has led to them "adopting a cautious and protective stance" (p.178). Similarly, Critchley (2020a) concluded, "Social workers are likely to continue to practice in defensive and risk-averse ways so long as the very survival of infants at risk

is conceptualized as their professional responsibility" (p.902). Hodson (2011) found that there was a strong focus on risk measurement and management in pre-birth assessments, rather than focusing on the child's needs as a whole and how these could be met by the family. Critchley's (2018b) thesis found some suggestion of social workers basing their decisions for unborn babies on "the very worst experiences from their professional careers" (p.179). This was based on two professionals who had infants placed in the care of their parents, one of whom was later seriously injured and another who died. There was a sense of "professional precarity" (Critchley, 2018b, p.260) felt by social workers when they considered taking 'risky' decisions to allow 'vulnerable' infants to return home with their parents after birth. This tendency towards a risk averse approach is concerning given findings that the likelihood of infants BIC successfully being reunified with their families is so low (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Pearson et al., 2020).

3.7.5. Post-removal work

There is a growing evidence base around the repeat cycle of removals with Broadhurst and colleagues focusing on this area in their 'Born into Care' series, which is ongoing. Whilst much of this research does not directly refer to pre-birth assessments, "Practitioners agree that this is a significant cause of 'revolving door' cases, whereby the same families lose a number of children in subsequent family court cases at significant financial cost to local authorities and emotional cost to those involved" (McPherson et al., 2020). This is because further pregnancies in parents who have had children removed are likely to trigger a pre-birth assessment (Broadhurst and Mason, 2013) and women who have had an infant removed are more likely to have another child

in the following years (Grant et al., 2014). Broadhurst and Mason (2017) concluded that, “child removal can no longer be seen as the end of the problem” (p.45) with parental issues being exacerbated by removal (Wall-Wieler et al., 2018b; Wall-Wieler et al., 2018c) and the potential for a cycle of pregnancies and removals following on. The BIC series has provided a compelling moral argument for providing continuing support to families, to avoid the destructive and distressing cycles of repeat pregnancies and care proceedings (Roberts et al., 2017) as both the humanitarian and financial costs of these repeat removals are high (Broadhurst and Mason, 2013; Broadhurst et al., 2017a, 2017b). Despite this work often being directed by courts (Broadhurst et al., 2015), parents who have experienced removals often ‘fall down the gap’ between children and adults services as they are not seen as welfare subjects in their own right (Broadhurst et al., 2013) There is a concern that, “Once the baby is removed, so is the professional care” (Marsh, 2016, p.174) leaving parents in a precarious position.

In response to this, a number of services are being introduced to support parents and reduce the risk of further removals. Whilst this area of practice is outside the remit of pre-birth social work at the present time, it is important to consider the possibility of how this may reduce the need for further pre-birth social work, as Broadhurst et al. (2018) found that 47% of infants BIC were not the parents first child to be removed from their care. Services such as ‘Pause’, ‘MPower’, ‘Reflect’ and ‘Positive Choices’ are individually tailored, relationship and strengths based, trauma informed programmes delivered to women and in some instances their partners, who have experienced or are at risk of recurrent removal of infants (Boddy et al., 2020; Boddy and Wheeler, 2020a;

Cox et al., 2017; Roberts et al., 2018). The services have shown promise in terms of improvements in emotional wellbeing, housing and financial security, engagement in education and employment, stability in relationships (Boddy and Wheeler,2020b) a reduction in substance misuse and increased engagement with services (McCracken et al., 2017). There is also evidence of a significant reduction in the rates of infants entering care in LAs where services were available in comparison to LAs where they were not (Boddy and Wheeler, 2020a; Cox et al., 2017; McCracken et al., 2017). Some of the schemes have a requirement that women agree to use a form of long-acting reversible contraception (LARC, Cox et al., 2020) which has raised ethical considerations (Boddy et al., 2020) and is subject to continued evaluation.

There is a call for further investment into such post removal initiatives (Alrouh et al., 2020; Boddy and Wheeler, 2020, Boddy et al., 2020; Cox et al, 2017). Key arguments for this are around reducing the financial and resource burden of recurrent proceedings, as well as the lasting and wide-reaching impact that these experiences can have on families, with arguments that all parents who have experienced removal should be able to access this type of support (Boddy et al., 2020; MacAlister, 2022). Currently there is no statutory requirement for LAs to provide post removal support and access to these services varies across the country (Broadhurst et al., 2017). Learning from these approaches may also be applicable to developing more effective pre-birth work, although some aspects of the approaches would be difficult to balance with statutory intervention at a child protection level which is not voluntary in nature.

This section has explored how pre-birth assessments are undertaken and considered some of the challenges and opportunities that can present during pre-birth assessments. Ultimately these can impact on the outcome of pre-birth assessments, which shall be the focus of the next section of this review.

3.8. What are the outcomes of pre-birth assessments?

The potential outcomes of a pre-birth assessment mirror those of all child and family assessments; closure or transfer to other services, the provision of services under child in need or child protection, or consideration of PLO and application to Court for an Order to remove the baby after birth. No studies to date have holistically explored the outcomes for referrals regarding unborn babies in the UK. In one jurisdiction of Australia, Taplin (2017) found that of all the referrals regarding unborn babies in 2013, approximately two thirds were provided with some form of service following the referral and 12% were removed within 100 days of birth – five in the first week, and eight within one month. The outcome of pre-birth assessment work remains a gap in the current understanding of pre-birth practice. Some research has explored variations in outcomes, predominantly regarding the rates of infants being BIC, the focus of this section.

Before considering assessments that recommended removal, there are two studies which have considered child protection outcomes from pre-birth assessments; Baker (1997) and Hart (2001). Baker (1997) found variation across LAs in the number of unborn children being registered on child protection plans, with some LAs having high numbers registered but others having none. Interestingly it appeared that more rural locations had more

unborn infants registered than metropolitan areas. Baker (1997) suggested further examination of this variation was required, hypothesising that:

> “The differences are likely to lie in the policies and practices of the child protection agencies and workers in those authorities, rather than differences in the child protection needs of unborn children.” (p.226)

Hart (2001) also noted that there was significant variation in unborn babies having child protection plans. This data was gathered in 1994 and she hypothesised that could be as a result of child protection plans for unborn children only recently being introduced, and that LAs had been slow to implement this in practice. Both studies are now over 20 years old and this is an area of understanding that requires updating.

Moving on to the literature which explores rates of infants BIC, there is evidence of significant variation across England as discussed. This section focuses on the variation between LAs. Whilst all LAs have experienced increases over time, the North East, North West and South West have experienced the highest increases (Broadhurst et al., 2018). Bilson and Bywaters (2020) studied rates which included children entering care through section 20. They found both rapid increases of the number of infants BIC, as well as variation by local authority and region. The average in England was 48 in every 10, 000 live births between 2017 and 2018. This varied from the 25 LAs with the highest rates having an average 1 baby per 101 live births being born into care compared to the 25 local authorities with the lowest rates having an average of 1 in 542, more than five times lower. The Northeast has both

the highest proportion of infants BIC, as well as the largest growth of infants being BIC; a factor that is especially relevant for this research.

The reasons for these variations have been a recent focus of research. Bilson and Bywaters (2020) found evidence of a small correlation between the increase of infants born into care and deprivation scores. Other studies have also hypothesised that variation in rates could be partly due to the prevalence of risk factors within populations (Pearson et al., 2020), however there appears to be differences in practice too (Bilson and Bywaters, 2020; Pearson et al., 2020). Links have been made between Ofsted ratings and the number of infants BIC with highest numbers being found in LAs which require improvement (Bilson and Bywaters, 2020; Mason and Broadhurst; 2020). This could be indicative of risk averse or fear-based practice, with a view that removing the baby and 'working backwards' to provide a safe environment could be a safer option, which has been explored earlier within this review (see section 3.7.4). Practitioners in Mason and Broadhurst's (2020) study recognised that that Ofsted ratings were a driving factor in outcomes with some authorities citing that Ofsted intervention has "led to more defensive and overly risk-focused practice" (p.9).

The services available within regions also have an impact on the outcomes of pre-birth assessments. Mason and Broadhurst (2020) found distinct variation in families being offered parent and baby foster care placements, or placements within assessment centres following birth. Within London authorities, these placements were seen as routine and would often be offered before separation was considered, with some courts expecting this service to be offered to all families at birth. This is not the picture nationally. Other LAs,

especially those within the North East and Yorkshire, have very few placements of this type available, and this was attributed to budget restrictions (Mason and Broadhurst, 2020). There has been some evidence of a reduction of rates for infants entering care in local authorities where targeted interventions such as Pause have been put in place (Boddy et al., 2000). This raises ethical questions about the equality of opportunity across the country. When “the vast majority of children BIC will never return to their parents” (Bilson and Bywaters, 2020, p.e4) it is clear that parents should be given every possible opportunity to make changes and ensure that any removal of an infant at birth is only taken as a last resort. Currently, infants do not have an equal chance of being BIC (Broadhurst and Mason, 2020) and this is something that requires further research.

3.9. What are the experiences of those involved in pre-birth social work?

The final section of this literature review explores what is currently known about the experiences of families and professionals. At the time of writing, there is limited literature which focuses on the experience of pre-birth work for both professionals and families, although there is more literature which looks at removal at birth, as has been highlighted in other areas of this review. Mason et al. (2019) completed a rapid review of the knowledge on ‘experiences and challenges’ of pre-birth assessment and infant removal at birth as part of the NFJO Born into Care series. Their review had a wider scope than just social work. Whilst their work offers a comprehensive overview regarding experiences, it was important to include this section within the current literature review as the wider research focus of this thesis is on the experiences of social workers working with families before birth. Some of the

information from Mason et al. (2019) is summarised here, and the information is updated with more recent publications.

3.9.1. Families

The literature on the experiences of families during pre-birth assessment work highlights how stressful, overwhelming, and isolating the assessments can feel. As with other areas explored within this review, the literature is skewed towards removal and compulsory intervention meaning that it is not necessarily representative of all pre-birth practice, although some positive experiences relating to pre-birth practice in general are represented.

Issues with timing and delays in work, explored earlier, have a negative impact on families, leaving them feeling “in limbo” (Ward et al., p.224), or as though the involvement was “’hanging over’ the pregnancy” (Critchley, 2018b, p.121). Delays also led to a flurry of activity towards the end of the pregnancy with high demands being placed on parents within short timescales (Critchley, 2018b; 2019), which can result in an overwhelming number of appointments to attend (Critchley, 2018b; 2019; McGory et al., 2019). This can leave parents confused as to which appointments are most important and feeling fearful of disclosing that they are struggling to manage the appointments for risk of judgement (McGory et al., 2019). This rush of involvement had drastic negative impacts on some of the participants in Critchley’s (2018b; 2019) and Ward et al.’s (2010) studies, with participants discussing the impact on their physical and mental health.

Literature suggests that parents can feel disempowered and traumatised by involvement with social workers (Harrison et al., 2020) with a view that the

social workers are not really there for the mother, they are there for the baby (Cox et al., 2020) and that this has an impact on the way they are treated. Some mothers have reported feeling as though they are “illegitimate mourners” (Marsh et al., 2019). This has been interpreted as disenfranchised grief by researchers (Broadhurst and Mason, 2020a; Boddy and Wheeler, 2020; Marsh et al., 2019); as though the mothers did not have the right to play the role of the child’s mother nor a right to feel grief and loss. Some mothers in Boddy and Wheeler’s (2020) research reported feeling as though they were not seen as the mother of the infant and that their concerns were not taken seriously. One discussed being referred to as a “tummy mummy” (p.e11) during a professional meeting, further separating the mother and the child.

There are also high levels of shame and stigma around having professional involvement during pregnancy (Broadhurst and Mason, 2020a; Mason, et al., 2019; McGory et al., 2019), much of this research relates to parents who have experienced removals shortly after birth. Some research has found that mothers will hide the fact they had had children removed within their daily lives (Broadhurst and Mason, 2020a; Marsh, 2016; Marsh et al., 2019) which results in further isolation and limits any informal support networks that the mothers previously had. Many parents report fear of going out into the community following removal (Broadhurst and Mason, 2020a; Marsh et al., 2019). This can be a fear of seeing other children, as this reinforces their own feelings of loss (Broadhurst and Mason, 2020a; Marsh et al., 2019) or seeing people who knew they were pregnant for fear of having to explain what had happened (Marsh et al., 2019). Many parents have also reported feelings of professional stigmatisation, a feeling that their ‘cards were marked’ in the views of

professionals and courts (Broadhurst and Mason, 2020a), with the removal dominating any future decisions about their ability to parent. Boddy and Wheeler (2020) found that women's engagement with services was stigmatizing, with women being seen as the 'problem'.

Studies have evidenced the intense and lasting impact of infant removal on mothers, fathers and the wider family. The experience has been described by families as a painful and abrupt transition from happiness to sadness (Chambers, 2009), disempowering and traumatising (Harrison et al., 2020), devastating (Broadhurst and Mason, 2020a), causing distress, despair and confusion (Trew et al., 2022), being acutely painful (Broadhurst et al., 2022), and similar to grief (Marsh, 2016). These feelings of emptiness and despair can lead to suicidal thoughts and leave mothers feeling as though there is little reason to continue engaging with services (Broadhurst et al., 2022; Broadhurst and Mason, 2020a). The wider impact of removal was also highlighted with the breakdown of romantic or family relationships, especially when infants were placed in kinship care, loss of housing and welfare entitlement and an increasing likelihood of mental health and substance misuse issues being exacerbated by the removal (Broadhurst and Mason, 2020a). All of these factors were seen to limit the chances of reunification and further reduce the desire of mothers to engage with services post removal. Broadhurst and Mason (2020a) concluded that there was little surprise that women often went on to have subsequent pregnancies in light of this.

Despite the literature on family experiences being overwhelmingly focused on negative aspects, there are some positive experiences evident within the literature, although these tend to stem from situations where children have

remained in their parents' care. Flaherty (2021) interviewed two women whose babies remained in their care following birth and they reported that they could have a positive relationship with professionals during assessment, but this needed to be based on respect. Both mothers had previous experiences where infants had been removed where they felt they were treated differently. Similarly, Ward et al. (2010) identified positive experiences by parents, especially when the social workers were able to be sensitive, candid and able to listen without judging. This has also been discussed more recently by Trew et al. (2022). This relates back to the importance of relationships, which has been highlighted by several authors, as discussed previously (see section 3.7.3).

3.9.2. Professionals

This section considers the experiences of professionals involved in pre-birth practice, focusing on social workers but drawing on literature from other professions due to the limited literature available on social work. Some of the literature has already been explored within this review; specifically, around the lack of guidance and confusion about how to undertake pre-birth assessments (see section 3.6). This section will focus on the personal experiences of professionals and the emotions attached to this type of work.

Critchley's (2018b; 2020a) work did not aim to specifically explore the experiences and emotions of social workers undertaking pre-birth assessment, but the research offers some insight. She found that social workers felt that there was a big responsibility associated with pre-birth work and that social workers questioned their decision making and worried about making the right decisions for 'vulnerable' infants. Hart (2001) also noted that,

“Such decisions must be amongst the most challenging within the profession, arousing strong emotions about state intrusion but with serious consequences if they are 'wrong'” (p.207), so unsurprisingly, there are some indications of the work being challenging emotionally. Critchley (2018b; 2020a) highlighted the work could be draining and anxiety provoking, with one participant mentioning that they had difficulty sleeping because of their involvement with pre-birth work. Critchley (2018b) commented that most of the social workers she spoke to presented as confident and emphasised their ability to cope with the work. She reflected that this may have been a choice that participants made not to discuss the emotional aspects of the work. The experiences of social workers, and the emotions around this work, is a gap within the literature at present. This study adds to the current knowledge base and provides a deeper understand of social workers’ overall experiences of pre-birth assessment work.

The remainder of the literature explores the experiences of professionals involved in the removal of infants shortly after birth which is arguably “a traumatic event for all concerned” (Marsh et al., 2019, p.e8). Much of this literature is drawn from outside of social work. One prison officer in Powell et al.’s (2020) study reported that their involvement in removal at birth was more difficult than any other aspect of work in their professional career, which had included work with victims of torture. Similarly, midwives in Marsh et al.’s (2019) study reported their involvement as the most challenging and frightening aspect of their work. This work can be extremely challenging emotionally and social workers and case workers in Marsh et al.’s, (2019) study spoke of the cumulative toll of being involved in removals at birth. One

spoke of the distress they felt being similar to that of a bereavement. Similar findings have been reported for midwives, with the experiences of emotions similar to a stillbirth (Everitt et al., 2015; Marsh et al., 2016), but that those emotions could remain longer than any other aspect of the work (Marsh er al., 2016). Some participants in both Everitt et al.'s (2015) and Marsh et al.'s (2019) studies reported that the memories of removal and the faces of the women stayed with them. Marsh et al. (2019) and Critchley (2018b) both found some indication that whilst the emotional burden of the work could be high, it also reduces with experience, but there are concerns that this may suggest a detachment from the work which could have a negative impact later (Marsh et al., 2019).

Managing emotions and being able to remain professional has been cited as a challenge for all professionals involved. Studies have suggested difficulties of trying to balance empathy and closeness to the mother with keeping enough emotional distance not to break down (Powell et al., 2020) as, "Empathy is good but falling apart won't help the woman. You need to be there for them and stay strong. It's not your grief, it's their grief and you learn to hold or rein in that emotion" (Marsh et al., 2019, p.e4). Trying to remain professional during a removal is challenging (Everitt et al., 2015) with social workers in Marsh et al.'s (2019) study reportedly trying to stay numb and responding clinically in the moment to deal with this. In the long term, there are questions whether this might result in professionals becoming too detached from the process, with one midwife in Marsh et al.'s (2019) study saying, "It's finding the balance of building inner strength without losing your compassion and that's sometimes a very fine line to walk." (p.e8). Focusing on the baby and believing that

removal is the ‘right’ option for the infant is another way professionals try to cope with the stress (Marsh, 2016). Social workers and Midwives in Marsh et al.’s study (2019) felt that if they believed that the baby could be hurt if they remained with the family that it made the removal easier to live with, with similar findings in other studies focused solely on midwives (Everitt at al., 2015; Everitt et al., 2017; Marsh et al., 2020). Even when professionals saw the removal as the ‘right’ course of action, there were still strong emotions attached to the work, which case workers in Marsh et al.’s. (2019) described as “insensitive, cruel, upsetting and distressing” (p.e6).

The level of emotions experienced by professional in the literature raises the question of how they are supported with this, and this has been highlighted as important within the literature (Everitt et al., 2015; Hodson, 2011; Marsh et al., 2019; Powell et al., 2020). Hodson (2011) found differing levels of support for social workers and commented on the high volume of work that they were dealing with, with some having very little support. Similarly, in Everitt et al.’s (2015) study, midwives reported feeling both unprepared and unsupported with the work. Social workers in Marsh et al.’s (2019) study found debriefing with a colleague essential to help manage the emotions, and midwives in the study reported needing support and time out after a removal, although this was not always possible in practice. Having a good work life balance or implementing self-care strategies could reduce the impact of the emotions (Marsh et al., 2019) but the support for professionals who are working with families undertaking pre-birth assessments remains a relatively underexplored area of the literature.

This section has considered the experiences of families and professionals involved in pre-birth practice. Much of the literature is focused on removal rather than pre-birth assessment in general, however it highlights how difficult pre-birth work can be for all involved. For families the involvement can be overwhelming, and removal can lead to stigma, shame, trauma, and isolation which can have a wider impact on parents lives if they are not effectively supported during this time. For professionals, there are indications that the work is challenging and anxiety provoking. Much of the research on professionals is based on midwives and centred around removal. What is clear is that being involved in the removal of an infant is extremely difficult and additional support to ensure that emotions around this are managed.

3.10. Conclusion

This literature review has highlighted how pre-birth practice is complex and fraught with ethical tensions. Pre-birth assessments are often undertaken as a result of multiple risk factors which are present in parents' lives, with parents often having multiple support needs of their own. Pre-birth practice appears distinct in some ways to practice with children after birth, with a firmer gaze on parents, or more specifically the mother, which has been criticised in the literature. Across the UK and the western world, there is evidence that assessment and intervention before birth is increasing, with the number of infants being BIC rising in the UK, Australia, Europe and Canada. These rises have not been supported by an increased focus on pre-birth practice in research of guidance and whilst there is now more focus on pre-birth assessment in research, social workers are still undertaking assessment without clear guidance or a clear underpinning evidence base. This has led to

significant variations in outcomes for infants across the country. The assessments which are being undertaken are often not standardised or informed by research and this has led to LAs and individual social workers creating their own focus of assessment. The impact of austerity on resources and services is also cited as a reason for variation in rates of removal with concerns around a ‘postcode lottery’ influencing what support and services parents might be able to access. Pre-birth assessment work has been seen to be challenging for both families and professionals, with high levels of emotion being associated with the work, especially in instances where infants are removed from their parents’ care.

The literature review highlights several gaps in our current understanding of pre-birth practice. One thing that stands out across the literature is the focus on removal, with very little research exploring pre-birth practice more holistically. Many studies focus on instances where removal has been recommended, but very little is known about assessments that have led to closure, transfer to other services, or support under child in need. There is more information on outcomes of child protection, but this is also limited. Further research is required which considers pre-birth practice more broadly so that we can understand how different situations lead to different outcomes for children and families. Research has highlighted gaps in our understanding around how social workers learn to undertake pre-birth assessments, with calls for more research into how they are prepared for this area of practice, and then how this influences decision making. The experiences of professionals and families involved in pre-birth work are lacking within current literature. Whilst there have been some attempts to explore this, social workers

experiences are especially lacking with no studies focused solely on social workers views on the work.

The current picture presented suggests that pre-birth practice is indeterminate and messy, guidance is lacking at a national and local level leaving practice to be shaped through experience. This study will focus on exploring the experiences of social workers undertaking pre-birth work holistically, to address some of the gaps identified in this literature review.

4. Research Methodology and Methods

4.1. Introduction

This chapter outlines and critically appraises both the methodology underpinning the study and the methods employed for data collection and analysis. The chapter begins with an examination of reflexivity in research and why this is important for my role as an insider researcher. The research problem, aims and objectives are then outlined before these are considered from a methodological standpoint. All researchers make theoretical assumptions about knowledge and reality when designing and carrying out their studies (Malterud, 2016) and these ultimately impact on the findings of their studies, it is therefore important that these are examined for transparency. The chapter will then move on to explore the methods used, including ethical considerations and practical aspects of the research process such as designing the study, recruitment, sampling, and analysis. The research decisions are critiqued throughout, with links to how the decisions made have impacted on the quality of the study and how they might have influenced the findings.

4.2. Reflexivity and being an insider researcher

Reflexivity is essential in high quality qualitative research (Braun and Clarke, 2013). It is a form of critical reflection undertaken by the researcher during the research which articulates the researchers influence on the study (Finlay, 2002a; 2002b). Reflexivity involves critically examining how our own experiences and views might influence the design and process of the study, and subsequently shape the knowledge that is produced (Lazard and McAvoy,

2020; White et al., 2006). This section will explore how I have used reflexivity throughout this study.

There are different forms of reflexivity and this research incorporates both personal and functional reflexivity. Functional reflexivity is focusing on how the research processes may influence the research, whereas personal reflexivity is about bringing the researcher into the research process (Wilkinson, 1988). My motivations to undertake this research were deeply rooted in personal and professional experience, and not exploring my own positionalities would be a missed opportunity to consider how this has shaped the research. Although critics of qualitative research see personal experience and subjectivity as a source of bias (see Denzin and Lincoln, 2011), Braun and Clarke (2021) view utilising your own experiences and reflections as a researcher as a strength within qualitative research.

In terms of functional reflexivity, the impact of a researcher's own experiences need to be explored to consider the impact they may have on the study (Braun and Clarke, 2021; England 1994). Personal experience has been long accepted as a valid reason to undertake research (Etherington, 2005) and yet it is not without additional complications (Mallon and Elliott, 2021). One of these complications can be a position as an insider researcher (Blythe et al., 2013; Taylor, 2011) and an important aspect of reflexivity is considering our status as an insider or an outsider (Gallais, 2008) and the impact this may have on the study. Insider research is where the researcher has common characteristics with the participants (Braun and Clarke, 2013) or where it is undertaken with a group, community, or organisation where the researcher is also a member (Fleming, 2018). Insider researchers can also be someone with

previous practice or knowledge of the group, even if they are no longer a member (Hellawell, 2016) and some argue that insider status exists on a continuum, depending on the closeness of the researcher to the topic being researcher (Mercer, 2007). Whilst I am no longer a practising social worker, I have remained registered with the English regulator Social Work England, and I work in social work education within the geographical area of study. This study is also motivated by my own experiences of pre-birth assessment in practice. Therefore, I would still be defined as an insider researcher within the broader definition of the concept.

Being an insider can be dealt with in several ways; it can be minimised, utilised, maximised or incorporated (Wilkinson and Kitzinger, 2013), with each approach having a different impact on the study. Minimising the researcher voice and not exploring their own experiences of the research topic can offer the researcher more anonymity and can give a sense of objectivity. However, this also masks their power, and it can make the research appear dishonest should the researcher's true positionality emerge at a later point (Wilkinson and Kitzinger, 2013). The anonymity that this approach offered was appealing, as I have discussed my discomfort and feelings of vulnerability in writing about my motivations to explore this topic (see section 1.3). Mallon and Elliott (2021) found that researchers with personal connections to the topic can feel conflicted about their positionality, worried that others see them as naïve, which has been a worry throughout this research process. Despite this, I decided that being honest about experiences of pre-birth assessment and motivations of the study was too important not to acknowledge and that my

own discomfort was a worthwhile expense to ensure the research was authentic and transparent.

Utilising the researcher's insider experience is much more common and can have clear benefits to the research process (Wilkinson and Kitzinger, 2013). One of the benefits is the knowledge that insider researchers can bring to the process, which can lead to research questions which are based on rich understandings of the subject matter (Fleming, 2018). The position can aid recruitment (Ellis and Berger, 2003; Fleming, 2018) and support the data collection by allowing trust and a shared understanding to be established between the researcher and participants (Gair, 2012). This can lead to deeper dialogue between the researcher and the participants (Harvey et al, 2016), and more detailed analysis and interpretation of the findings, based on the shared understanding and context of the topic (Fleming, 2018). However, utilising the insider position does not require disclosure of the researcher's own experiences within the research, leaving issues of power and voice largely unaddressed (Wilkinson and Kitzinger, 2013). Maximisation of the insider role involves studying the experience of the researcher within the research and is a much less common approach, as it can feel so exposing for the researcher (Wilkinson and Kitzinger, 2013). Maximising the insider role often involves an autoethnographic component within the research. Whilst this research does not utilise an auto-ethnographic method, I have clearly outlined some aspects of my own experience and drawn on these to explore my positionality within the research, therefore I have used a combination of utilising and maximising my role as an insider.

There is no right or wrong way to practise reflexivity (Kara, 2022), but certain processes can strengthen reflexivity in research. Positionality is an integral and positive element of qualitative work which rather that undermining the findings, exploring this clearly defines the boundaries within which the research was produced (Jafar, 2018). Researchers should demonstrate their situatedness and personal investment in the work (Gergen and Gergen, 2000). I took a number of steps to address the potential for my own experiences to influence the findings of the study and to provide a clear indication of my own experiences of pre-birth assessment. By including a reflexive piece on my motivations to study the topic, I have been clear about my own positionality on the topic. I wrote this piece prior to starting data collection so that I had time to reflect on my experiences and consider this when designing the research study. By providing my own personal disclosure of my own experiences and thoughts, rather than omitting this from the research, audiences will be able to take this into account when reading the work, which is important for high quality qualitative research (Hardy et al., 2001). I kept a reflexive journal throughout the research process, including the recruitment, data collection, transcription, coding, analysis and write up phases of the study. Braun and Clarke (2021) recommend the use of a reflexive journal throughout the research process as a “repository for documenting and storing thoughts for subsequent reflection, interrogation and meaning-making" (p.19). It also allowed me to expand on my interactions with the participants, with additional comments and perceptions (Halcomb and Davidson, 2006) that may have been otherwise lost. Speaking to others can also add depth to reflexive

practice (Lazard and McAvoy, 2020), so throughout the research I spoke to my colleagues and supervisors to aid my reflexivity.

4.3. Research problem, aims and objectives

Research needs to begin with the identification of a problem, which can then be narrowed down into specific research questions (Yegidis et al., 2018). It is important that the topic addresses an area of practice that requires further exploration to inform policy, guidance, or decision-making within social work (Rubin and Babbie, 2008). As Yegidis et al., (2018) explain, a social work problem is “an undesirable condition attributable (at least in part) to the nonexistence of some potentially useful knowledge” (p.52). As was explored within the literature review (Chapter 3) pre-birth assessment first emerged as an aspect of child and family social work in the 1970s and since then, the number of pre-birth assessments undertaken appears to have grown considerably. Despite this, research on pre-birth work remains scarce. Understanding both family and social workers' experiences of pre-birth work is a gap in the current literature. At present, there are only two studies that explores the experiences of families involved in pre-birth child protection (Critchley, 2018b; Trew et al., 2022) with four further studies exploring families’ experiences of infants being removed at birth (Broadhurst and Mason, 2020; Chambers, 2009; Marsh, 2016; Marsh et al., 2019). To date, there are only two pieces of research that have explored some aspects of social workers' experience of the work (Critchley, 2018b; Marsh et al., 2019). More studies are currently published on midwives’ involvement in pre-birth processes (Everitt et al., 2015; Everitt et al., 2017; Marsh et al, 2014; Marsh et al, 2016; Marsh et al., 2019), although these focus on removal at birth.

The lack of guidance, assessment processes and rising number of assessments and removals highlight a need to explore the experiences of social workers working within this field of practice. This research therefore sought to explore the experiences of social workers involved in pre-birth assessments within one geographical area of England. To achieve this several objectives were proposed:

- To explore social workers' understanding of pre-birth assessments and how these relate to other aspects of children and families' social work.
- To explore the impact on social workers of undertaking pre-birth assessments and how they feel about this work.
- To establish what support social workers have received when working with families before a baby is born, or how they would like to be supported.

It is hoped that social workers' experiences of pre-birth assessment can be used to inform practice.

4.4. Methodological considerations

All researchers make assumptions about reality and what constitutes knowledge (Braun and Clarke, 2021) and have ontological and epistemological positions which need to be documented and explored to justify the research methodologies used. Ontology explores what constitutes reality and truth, epistemology considers how knowledge about the world is constructed and how it can be acquired (Ravitch and Carl, 2021). A researcher's ontological position is likely to influence their positionality and how they seek to complete research (Thomas, 2017) which in turn will be

represented by the epistemology they are likely to draw on. Ontological positions range from realism, an approach which believes that there is a ‘truth’ and ‘reality’ to study (Pruzan, 2016) to relativism, where there is no one true reality, but multiple realities that are socially and culturally constructed (Burr, 2019). Epistemology can also be seen as a continuum, spanning from interpretivist approaches to positivist approaches. Positivist approaches focus on studying observable facts (Flick, 2015) and measuring outcomes to develop causal relationships between factors (Hammersley, 2012). Interpretivism sees research as subjective and value based, that reality is something that we interpret, and that each context is unique (Kara, 2022). Whilst epistemic and ontological positions are presented here as diametrically opposed, the distinctions between them are not that clean and uncomplicated (Weber, 2004).

Our ontological and epistemological positions are often influenced by our education, training and professional backgrounds (Braun and Clarke, 2021). There is growing interest in critical realism as an ontological and epistemological position in social work research (Anastas, 2012; Houston; 2010; McNeill and Nicholas, 2019). Critical realism holds a realist ontology (Yucel, 2018) in that it purposes that there is a reality and social structures that exist independently from researchers and participants (Braun and Clarke, 2021; Dore, 2018). Despite the reality of the world that critical realism purposes, it sees our understanding of that world as being shaped by individuals’ interpretation and experience (Dore, 2018; Pilgrim, 2014) meaning that it utilises a subjective epistemology (Brannick and Coghlan, 2007). Social work is a profession which deals with a range of situations and recognises the

complexity and ambiguity of practice at times (Ambrosino et al, 2016). Due to this, practice and theory need to be viewed in different ways (Miller et al., 2008), with no one source of ‘truth’ being possible. Generally, there is an acceptance that other factors influence ‘reality’, and that there can be multiple versions of reality that all hold ‘truth’ (Anastas, 2019). Applying this methodological perspective to this study, a critical realist approach would see that there is a world where pre-birth assessments are undertaken but everyone’s experiences of this is different, and research can only access a person's own representation of this reality (Willig, 2013). A critical realist approach aligns to the research aims and objectives where social workers might have a broad range of experiences which can contribute to the understanding of pre-birth social work practice. In exploring participants multiple ‘truths’, some insight will be gained into how pre-birth social work is experienced by social workers, and what impact it can have, in order to develop practice within this area.

Critical realism recognises that the researcher cannot simply stand outside of the human and social reality that they are researching (Pilgrim, 2014). The researcher must expose their own interest and emancipate themselves through reflexivity (Brannick and Coghlan, 2007). Through both utilising and maximising my own experiences within the research (Wilkinson and Kitzinger, 2013) I have ensured that it is methodologically sound and that my own interests in the topic can be considered. Critical realism has faced criticism from both positivists and interpretivists for either not being realist enough or being too realist however, Birke (2000) explained, “perhaps sitting on the fence can provide a better view, a means to try to articulate with the worlds we study,

instead of distancing ourselves from them" (p.596) which may be a strength of this study.

4.5. Selecting a method

Interviews are often cited as one of the most popular forms of data collection (Fielding and Thomas, 2016; Robson and McCartan, 2016) and an approach which is favoured within social work research (Ferguson, 2016). They offer an insight into the subjective experiences of participants (Davies, 2007) and can explore their perceptions of a subject (Braun and Clarke, 2013). This research aims to explore the experiences of social workers undertaking pre-birth assessment work and so in-depth qualitative interviews were an appropriate method for data collection.

There is a concern within social science that interviews are over-used (Potter and Hepburn, 2012; Silverman, 2017), so alternative methods were explored prior to a method being selected. Focus groups can offer a wider variety of perspectives than interviews and gather consensus or diversity of experiences around pre-birth assessment (Morgan and Hoffman, 2018). They also allow for more data that can be gathered in one setting than interviews (Padgett, 2017). In this research, they were not used as the aim was to obtain detailed personal reflections from participants, promoting depth rather than breadth of experience. Using focus groups to elicit this kind of information could have led to under-disclosure, as well as ethical considerations around the comfort for the participants in sharing personal experiences within group settings (Morgan and Hoffman, 2018) as social context can influence people's responses (Grey, 2017).

Qualitative surveys could have also been used and would have allowed for participants to reflect on their experiences in private. They are ideally suited to sensitive topics (Moule, 2018) and the anonymity of surveys can result in more truthful answers (Robson and McCartan, 2016) which would have been beneficial to the research question and aims. Surveys also offer convenience for both participants and the researchers (Leddy-Owen, 2016) and would potentially reach a wider number of social workers (Grey, 2017). Despite the benefits, a qualitative survey approach was excluded primarily due to their lack of flexibility (Braun and Clarke, 2013). They do not allow follow up questions, which may add context and depth to the responses (Leddy-Owen, 2016). For this study, the depth and context of participants' experiences was too important to the research questions and aims for a survey to be used, so interviews were deemed to be the most appropriate method of data collection.

A semi-structured approach to the interview was chosen. Semi structured interviews include an outline structure for the questions, but the sequence of questions is participant led (Roulston and Choi, 2018). This approach was chosen as it allows a guide for the questions but leaves space for participants to expand on and elaborate on what they feel is important (Alsaawi, 2014; Brinkmann, 2018). Using a semi-structured approach allows participants to direct the conversation in a way that aligns with their own experiences (Brinkmann, 2018). There are concerns in research literature that interviews can be poorly carried out (Potter and Hepburn, 2012; Silverman, 2017) and the following sections will clearly explain the research decisions made within this study to ensure that they are transparent and justified.

4.6. Ethical considerations

Ethical approval for the study was requested through the University of Dundee's Ethics Committee in April 2021 (see Appendix A, section 10.2) and was granted by June 2021, prior to any data collection being undertaken. Ethics need to be considered as an ongoing process (Braun and Clarke, 2013) as issues may present at any stage of the research (Sobočan et al., 2019), therefore, ethical considerations were reviewed on a regular basis during supervision. Attention to ethical considerations is especially important within social work research, as, "by their professional discipline, code of ethics, or research foci are expected to demonstrate particular sensitivity to vulnerable populations, issues of social justice, conflicts of interest, and respect for dignity and privacy." (Sobočan, et al., 2019, p.805)

The British Association of Social Workers, (BASW, 2022) recommend adherence to the British Psychological Society's (2014) 'Code of Human Research Ethics'. This includes the underlying principles of respect for the autonomy, privacy and dignity of individuals and communities, scientific integrity, social responsibility and maximising benefit and minimising harm. These principles cover the requirement to maintain privacy and confidentiality of participants, to seek informed consent for participation, and ensuring the participants are aware of their right to withdraw from the study at any time (Braun and Clarke, 2013). The guarantee of confidentiality was especially important within this research context, as being an insider researcher who works within social work education in the geographical area of study, it is likely that the participants and the researcher may know the same people or may come into contact on a professional basis. Confidentiality and anonymity were

also important due to the nature of the discussions, with some participants being extremely forthright and critical of practice and so ensuring that their comments could not be attributed back to them was very important. For this purpose, pseudonyms were used within the study with participants being allocated a name during the transcription process. When services, children, or family member names were mentioned, these were removed and replaced with [service], [local authority], [mother], [child] during the transcription process so that the area of practice could not be identified.

All participants received the participant information sheet (see Appendix B, section 10.3) and informed consent form (see Appendix C, section 10.4) prior to agreeing to take part in the study. To register their interest in the study, participants had to complete an online Microsoft Form survey (see Appendix D, section 10.5) which outlined the research question and aims clearly, ensuring that they were aware of the focus of the research from the start. All data was stored safely in line with data protection legislation and the University of Dundee's research guidance. There were no paper documents involved in the study, but digital documents were stored with password protection on the University's servers.

Any research has the potential to become sensitive in nature (Hughes, 2004) which then may present a risk of harm to the participants. This study could be considered as sensitive due to the emotive topics discussed. In their seminal work on sensitive research Lee and Renzetti (1990) define this as research which, "potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding and/or the dissemination of research data"

(p.512). Revisiting distressing memories and experiences could be upsetting, and some participants may have been involved in the removal of infants or have experience of children being harmed during their work with families. Whilst all participants were trained and qualified social workers, the interviews could still have brought up information they found distressing, as discussed when exploring my own motivations to explore this topic. To manage this possibility, I implemented several strategies to ensure that the project was ethically robust, and that the safety and wellbeing of the participants was guaranteed as much as was possible. All participants were recruited on a voluntary basis, and it was made clear from the start of the interviews that they can pause or stop the interview at any time, should they need to take a break or no longer wish to participate. As a social worker myself, I am experienced in speaking to people about emotive topics. I can recognise cues that the conversation may be too difficult, and I would not have continued any line of conversation unless the participant was certain they wanted to do so. If any participant became distressed, they were offered an opportunity to move onto a different topic or take some time out. Participants were also sent the interview schedule ahead of time so that they could decide to opt out of certain questions or the whole study, if they felt that it would have a detrimental effect on their wellbeing. Prior to commencing data collection, I compiled a list of all NHS talking therapy support services within the geographical area which was offered to all participants (see Appendix E, section 10.6). It is important to note that whilst some participants experienced heightened emotions during the interview process, that none of them became overly distressed. Many participants reported that they found the interview process cathartic as it gave

them an opportunity to explore some of their feelings in more depth than they had previously been able to do.

4.7. Developing the interview content

It is important that interviewers are well prepared with a good sense of what topics are to be explored during the interview, and what they hope to learn (Roulston and Choi, 2018). However, qualitative interviews often evolve during data collection, as new issues or areas of interest arise (Charmaz, 2002; McGrath et al., 2019). The original interview guide was influenced by the literature and aimed to explore gaps which had been highlighted in the literature review (see Chapter 3). This guide was developed ahead of starting the study and approved through the ethics process, but reflections on the questions led to them being adapted slightly over the course of the interviews. The original guide was used with the first two participants and then adapted based on my reflections on these interviews and feedback from the first two participants. Whilst piloting interview schedules is seen as good practice (Padgett, 2017), there is often little scope for this in smaller scale research projects (Braun and Clarke, 2013). Although the content of the interview guide changed slightly over the course of the study, the topics for discussion remained the same throughout all ten interviews.

The final interview guide is available in Appendix F, section 10.7.

4.8. Participant recruitment

Recruitment processes are often not outlined in detail in research papers, yet the people that take part impact on the knowledge we are able to produce

(Kristensen and Ravn, 2015). This section will outline the recruitment phase of the study in detail and explore some of the challenges that this posed.

4.8.1. Initial recruitment plans

Clear inclusion and exclusion criteria were developed during the application for ethical clearance to the University of Dundee. Researchers select interview subjects who are best able to discuss their experiences relating to the research questions (Kristensen and Ravn, 2015) and so for this study, the individuals needed to have been a qualified and registered social worker and to have had experience of undertaking one or more pre-birth assessments whilst in practice.

The initial plan for research dissemination was to contact Workforce Development (WFD) leads or Principal Social Workers (PSWs) for Child and family Services in geographically relevant LAs via email, asking them to disseminate the information to relevant teams within their LA. Using 'mediators', people who act between the researcher and the participants, can lead to higher recruitment than using indirect methods such as social media or leaflets (Kristensen and Ravn, 2015). This method was chosen in the hope that it would allow for equal distribution of the research across the region. Initial introductory emails were sent to contacts in all LAs, and WFD leads and/or PSWs within the region. Those who agreed to disseminate the research were then sent an email with an overview of the study (see Appendix G, section 10.7), the participant information sheet (see Appendix B, section 10.3) and a link to an online Microsoft form for any interested participants to complete (see Appendix D, 10.5). This process started in June 2021 and follow-up emails to relevant individuals were sent between June and October 2021. Whilst it was

recognised this method of dissemination would not capture people who were no longer practising or registered, it was hoped that these individuals could be reached via word of mouth.

4.8.2. Issues which arose with recruitment

Whilst participant recruitment is often described in textbooks as a linear and straightforward process, in reality it is more complex than this (Mirick et al., 2017) and the initial plans for this study presented more challenges than anticipated. Recruitment can be hard to plan as it is reliant on other people to respond, which can be unpredictable (Kristensen and Ravn, 2015). Issues with recruitment remain a common issue within research (Manohar et al., 2019), and the recruitment strategy for this study had to be changed as a result of delays that were experienced.

An unanticipated challenge with recruitment was getting the research disseminated to social work teams within relevant LAs. The initial strategy of contacting WFD Leads and PSWs was received with mixed responses, and whilst some delay was anticipated, I had not factored in the extended time that it would take for my research to reach relevant social work teams. Some LAs disseminated the research quickly and without any complications. Contacts in other LAs either did not respond or explained that the research needed to go through additional levels of agreement with senior management and/or research leads within the LA. Whilst this was expected, it creates an additional complex system of bureaucracy which needs to be managed before participants can be recruited (Kristensen and Ravn, 2015). Additional layers of approval also led to WFD Leads and PSWs needing to dedicate more time

to disseminating the research which can often present challenges when recruiting within busy professions (Broyles et al., 2011), such as social work.

Between June and October 2021, a considerable proportion of my research time and focus was dedicated to making further contact with individuals within LAs and by October 2021 only six participants had agreed to partake in the study, three having received the information within their LA, and three having heard about the research through word of mouth. As a result of the low uptake and the difficulties in getting the research disseminated, in October 2021 I decided to expand my recruitment strategy and share my research on social media.

4.8.3. Using social media

Social media has become more widely used in social work, with both social networking and professional networking. It is now being used for peer support, sharing practice and research, and professional networking (Jackson, 2019). The British Association of Social Workers (BASW, 2018) promote the use of social media as a way of “networking, communication and developing inclusive practice” (p.2) and Twitter has become one of the most popular social media platforms amongst academics (Holmberg and Thelwall, 2014). Greeson et al. (2018) found that more social work academics use Twitter as a platform to share information about social work research, practice and social issues than the general population. Jones et al. (2020) also found it to be an effective way of disseminating research to social workers.

I designed a research poster (see Figure 1: Research Poster below) and shared this from my personal Twitter and Facebook accounts.

Figure 1: Research Poster

A Tweet was shared on the 7th of October 2021 and within 48 hours the Tweet had been seen 5,456 times and been engaged with 323 times, it was re-tweeted 44 times by social work practitioners, academics, and services across the country. The information was also shared on Facebook, although it is not known how many times this was re-shared through the platform. Within 48 hours, an additional 11 people had registered interest in the study by completing the online form. This recruitment method was much more successful than my initial plans and allowed me to finish recruitment to the study.

4.8.4. Sampling strategy

Purposive sampling was used within this study, which involves selecting participants based on the information they can provide that is relevant to the study. This is an approach often used within qualitative research (Braun and Clarke, 2013; Schreier, 2018). The participants selected for qualitative studies should be able to offer "information rich" (Patton, 2002, pp.230) data that

relates to the research question. In addition to this, participants' availability and willingness to be involved must be considered (Etikan et al., 2016). Given the timeframe and scale of the study, having participants who were willing and available became a pragmatic decision. Within the sample, some stratification was considered. This refers to ensuring there is a range of different groups within the final sample (Braun and Clarke, 2013). For this study, this meant ensuring that there were participants included who had experience of working within a range of local authorities. Whilst qualitative research is not about ensuring the generalisability of the research (Flick, 2015), I was concerned that having too many participants from one LA could skew the data, over-report on specific local factors and processes, and not provide an overview of the experiences of social workers across the region. Similarly, having only newly qualified social workers (NQSWs) or only highly experienced social workers would offer limited insight into only a small section of child and family social workers. For this reason, participants were chosen based on their availability and willingness to partake in the research, balanced with their experience in terms of number of years qualified, and LAs where they had worked.

Sample sizes within qualitative research tend to be smaller than quantitative research (Braun and Clarke, 2013) but there is disagreement about how many participants are required for a sample to be sufficient (Mason, 2010). Some argue that there are no rules about how many people are required for a qualitative study (Parton, 2002) and Nathan et al. (2019) propose that "There is no magical number for an interview study; it is topic and context dependent." (p.401). What is important is that you need to have enough data to tell a rich and detailed story, but not to the extent that it would become difficult to engage

with within the timeframe of the research (Onwuegbuzie and Leech, 2005). The concept of ‘saturation’ is often used to justify the number of participants used within qualitative studies (Braun and Clarke, 2013). ‘Saturation’ is a concept which derived from grounded theory (Guest, et al., 2006) and refers to the point when no new information emerges from participants (Flick, 2015). Despite the popularity of saturation as a way of justifying sample sizes, its use has received considerable criticism (O’Reilly and Parker, 2012; Braun and Clarke, 2019, Mason, 2010). Braun and Clarke (2021) do not recommend the use of saturation when deciding on the number of participants to include within a study, and further argue that this method is neither useful nor theoretically coherent when using Reflexive Thematic Analysis (Reflexive TA) as a method of interpreting the data (Braun and Clarke, 2019), which was the intended method of data analysis for this study (see section 4.12). Decisions on sample size often need to be pragmatic in nature, and the financial and time constraints of a project can contribute to decision making (Braun and Clarke, 2019). Mason (2010) highlights that qualitative research can be very demanding and accessing larger samples can become impractical. This study aimed to recruit 10-12 participants with a view that this would allow a range of experiences to be explored, whilst being confined by the resources associated with a part-time Professional Doctorate programme. Malterud, et al. (2016) argue that the “sample adequacy, data quality, and variability of relevant events are often more important than the number of participants.” (p.7). This study sought to gain detailed and rich data from participants and a lower participant number is justified on both pragmatic and methodological grounds.

4.9. Profile of the participants

Ten participants took part in the study. All were currently, or had been, qualified and registered social workers. They ranged from NQSWs with around one year of experience, to social workers with over 10 years of experience.

Most of the participants were still practising social workers (n=8), with half of the participants continuing to work within teams that were involved in pre-birth assessments (n=5). Three participants had moved to different teams within child and family services where they were unlikely to be involved in pre-birth assessments. Two of the participants had left social work practice, one was no longer registered with the English regulator, Social Work England, the other maintained their registration but was not practising. Two participants had moved into management roles and were no longer carrying out assessments themselves, although they were involved in the oversight of them within their teams.

The participants had a combined experience of nine of the 12 Local Authorities within the North East of England which offered a wide range of experiences to allow an insight into pre-birth practice in this region. Many of them had worked within different local authorities during their time in social work. Some also had experience of practice in other regions of the UK.

Six of the participants were female, and four were male. 40 per cent of the participants being male was unexpected given that the most recent data suggests that 86% of the children and family social work workforce is female (DfE, 2021). The higher proportion of men taking part in the study is unexplained, as the motivations for responding to the recruitment information

were not explored in any detail during this study. See table 1 below for an overview of the participant demographics:

Participant	Gender	Years of experience	Practise Status
Annie	Female	10+	No longer registered
Bonnie	Female	6-10 years	Practising – in a team that is unlikely to undertake pre-birth assessments
Chloe	Female	2-4 years	Practising – in a team that undertakes pre-birth assessments
Daniel	Male	10+ years	No longer practising, still registered
Ella	Female	1-2 years	Practising – in a team that undertakes pre-birth assessments
Finlay	Male	4-6 years	Practising – in a team that is unlikely to undertake pre-birth assessments
Gabby	Female	10+ years	Practising as a manager – in a team that undertakes pre-birth assessments
Harry	Male	1-2 years	Practising – in a team that undertakes pre-birth assessments
Isabelle	Female	4-6 years	Practising as a manager – in a team that undertakes pre-birth assessments
Jake	Male	6-10 years	Practising – in a team that is unlikely to undertake pre-birth assessments

Table 1: Participant demographics

4.10. Undertaking the data collection

A key decision I had to make was whether to undertake the interviews in person or online. Face-to face interviews have been posited as the ideal way

to collect interview data (Saarijärvi and Bratt, 2021). Prior to the Covid-19 pandemic, there may have been little need to justify an approach that used face-to-face interviews, however because of the Covid-19 pandemic, the methods of collecting interview data needed to be scrutinised and justified in much more detail. The Covid-19 pandemic has meant it has been necessary at times to maintain physical distance from others which has brought into question the viability of undertaking face-to-face interviews (The National Centre for Research Methods, NCRM, 2021). The primary data collection period of this project was undertaken during the summer and autumn of 2021, at a time when legal restrictions around social distancing had been lifted, but the public in England were advised to remain cautious (Cabinet Office, 2021).

There were no logistical reasons for the interviews not to be conducted virtually. The participants within this study were social workers, and most were still practising. Social workers have been working from home using technology since the start of the pandemic (Kingstone et al., 2021), and have become familiar with videoconferencing software in their day-to-day work. There would have been clear benefits to completing the interviews online, such as not having to consider travel and distance when planning the interviews (Saarijärvi and Bratt, 2021). Whilst virtual interviews are often seen as a poor substitute for face-to-face interviews (Braun and Clarke, 2013) there is a growing view that they can be a valid alternative (Roberts, et al., 2021) and just as valuable as face-to-face interviews (Koruwel et al., 2019). Despite the growing weight of evidence in support of virtual interviews in research, I decided to make every attempt to undertake them in person due to the potentially emotive nature of the discussions. Campbell (2021) identified that whilst it is possible to convey

empathy through the digital medium, the physical distance can result in an emotional distance. Similarly, Foley (2021) questioned how this distance could impact the interviewer's ability to help the interviewee navigate through any distress. Face to face interviews reduce any delays in communication and increase the ability of the researcher to recognise body language and other non-verbal signals. They can also increase the possibility of creating a comfortable and safe atmosphere during the interview (Saarijärvi and Bratt, 2021).

The settings for the interviews were chosen by the participants as it is important that participants feel comfortable within the setting (Braun and Clarke, 2013) and allowing the participants to choose it can help to balance any power issues between interviewer and interviewee (Manderson et al, 2006). Half of the interviews were undertaken at the homes of the participants (N=5). One interview was undertaken at a local University, one in my own home and the remainder (N=3) were completed via Microsoft Teams, a videoconferencing program. It is of note that no participants chose to undertake the interviews in their place of work, although social workers are increasingly working from their own home (Kingstone et al., 2021). Despite trying to undertake all the interviews in person, some participants still opted to meet virtually. Anecdotally, these interviews felt less emotional than those which were undertaken in person, and this is something to consider when assessing the quality of the study. All interviews were recorded, with the recordings being stored on the University of Dundee system and deleted from all recording devices directly after the interview had concluded.

An unanticipated consequence of data collection was the emotional impact that it had on me as a researcher. As Sampson et al. (2008) explain, “One of the dangers of undertaking research which is fuelled by a desire to achieve answers to personal issues, anxieties and frustrations is that once undertaken you are exposed on a day-to-day basis to situations which trigger painful memories” (p. 926). Prior to starting this research, I knew it would likely have an emotional impact upon me. As outlined in section 1.3, my own motivation to undertake the research stemmed from personal experience and I was aware that there can be an emotive response to shared or similar experiences (Padgett, 2017). Despite feeling confident about my ability to manage this when I designed my study, it quickly became apparent that I had underestimated how taxing that I would find the process. Researchers can be emotionally and physically affected by research, especially when it is sensitive in nature (Woodby et al., 2011) although these emotions can also be seen as invaluable tools for the research (Johnson, 2009).

As someone professionally trained to discuss sensitive and challenging topics with people, I had assumed I would be able to manage my emotions during the process. Weiss (1994) proposed that the research interview is different to the professional-client interview, with professional distance being removed. Instead, researchers need to keep an “emotional middle distance” (Weiss, 1994, p.123) where they are close enough to experience the emotions of the participant but maintaining enough distance to ensure that they are still in control of their own emotions. This ‘middle distance’ brought me closer to the experiences of the participants, many of whom discussed upsetting experiences which presented similarities to my own work, which can make the

research more emotionally demanding (Kumar and Cavallaro, 2018). Whilst this was a challenge, I felt it added to the argument that the research was needed. As Beher (1996) wrote, social science “that doesn’t break your heart just isn’t worth doing” (p.176) so I had to find a way to acknowledge and manage my emotions around the research to continue. Emotion is core to the reflexive process (Wilcock and Quaid, 2018) and it is important that I reflexively evaluated how my own experiences may impact on the research (Yeun, 2011). Reflexivity is often used as a tool to evidence how trustworthy a piece of research is (Finlay, 2017; Jacobson and Mustafa, 2019) however, it can also be used to understand and address the impact of research on the researcher, especially when considering insider research (Kinitz, 2022). Using a reflexive journal and practicing reflexivity within supervision allowed me the opportunity to be placed within the research as an “emotional, feeling subject” (Arber, 2006, p.156) and work through the emotional challenges I experienced during the research process.

4.11. Transcription

The recorded interviews were transcribed orthographically, or verbatim, where all spoken words and sounds were transcribed (Braun and Clarke, 2013). Transcription is often thought of as a straightforward task (McGrath et al., 2019), but there are theoretical and subjective assumptions underpinning transcription (Jenks, 2018) and it is important that these are explored.

I transcribed all data myself and the transcription was completed within a week of each interview. Whilst transcription can be an arduous task (Braun and Clarke, 2013), being immersed in transcription can be beneficial in terms of getting to know the data, and starting to think towards analysis (McGrath et

al., 2019). Having one person both interview and transcribe the data also allows for more reliable interpretation (Easton et al., 2000), which is why I chose to transcribe the interviews rather than using a transcription service. Transcribing the interview as soon as possible after the interview allows the researcher to recall the event more clearly and can result in a higher quality transcript (Braun and Clarke, 2013). For this reason, most interviews were transcribed within 48 hours, and all within a week, of the interview.

Transcriptions are never fully objective or accurate representations of the interview process, as they can fail to capture many of the nuances of conversation (Jenks, 2018). Often decisions need to be made to ensure that the transcripts are fit for purpose within the research (Jenks, 2018). One of the decisions I made which could influence the meaning of the language was to include additional punctuation. Braun and Clarke (2013) recommend against the use of punctuation where possible, but it is recognised that readability needs to be considered when transcribing any interviews (Braun and Clarke, 2013; Jenks, 2018). I was careful to listen closely to the recordings and only include punctuation when it aided the readability of the discussion and that I did not inadvertently change the meaning of discussion through its inclusion.

4.12. Coding and Analysis

Braun and Clarke's (2021) model of Reflexive Thematic Analysis (Reflexive TA) was used to analyse the data. Thematic Analysis (TA) is often misrepresented in research as one general type of analysis, and not clearly explained within the research methods of studies (Braun and Clarke, 2006; 2018; 2021). There are many different types of TA which can be used in qualitative research and whilst all TA recognises the subjectivity of qualitative

research (Braun and Clarke, 2021), Reflexive TA also draws on the subjectivity of the researcher as a strength in the process. It sees researcher subjectivity as a tool or resource for analysis, rather than something which needs to be controlled (Gough and Madill, 2012). Recognising my role as an insider researcher who has been driven to explore the topic of pre-birth social work partly due to my own experiences, reflexive TA aligned to my positionality and afforded me the opportunity to utilise my own experiences within the research. Reflexive research recognises that knowledge is "inevitably and inescapably shaped by the processes and practices of knowledge production, including the practices of the researcher" (Braun and Clarke, 2021, p.12).

The model of reflexive thematic analysis proposed by Braun and Clarke (2021) involves a six-phase process as outlined below in Table 2.

Braun and Clarke's (2021, pp.35-36) Stages of Reflexive Thematic Analysis
1. Familiarisation with the data – Becoming deeply and intimately familiar with the content of the dataset.
2. Coding – Systematically working through the dataset in a fine-grained way.
3. Generating initial themes – Identifying shared patterned meaning across the dataset, developing candidate themes.
4. Reviewing themes – Assessing the candidate themes as how they fit in the overall data and considering the viability of the overall analysis.
5. Defining and naming themes – Fine-tuning the analysis and ensuring they are based on a strong core element.
6. Writing up – Formal writing up.

Table 2: Stages of Reflexive Thematic Analysis

Whilst the process is presented sequentially, the reality was that this was a recursive process. Braun and Clarke (2021) explain that good TA often involves going "sideways, backwards, and even around in circles" (p.36). The

analysis process took much longer than I had originally anticipated. I went back and forth through the stages a number of times before deciding on the final themes presented in the findings chapters. This process took place between November 2021 and April 2022.

Familiarisation was undertaken more than once; initially following each interview, after transcription, and then again after all interviews were completed, to consider the entire dataset. During this time, transcripts were read and re-read several times and audio recordings were revisited. McGrath et al. (2018) recommend that analysis needs to be started early within any qualitative study, as leaving it until all data is collected can become a "monumental task" (pp.1005). During the familiarisation stage, it is important that researchers are immersed in the data, whilst keeping a critical distance from it to allow critique and analysis (Braun and Clarke, 2021). Starting the analysis whilst data collection was ongoing also allowed for reflexive responses. During this time, I used my reflexive journal to make notes about my initial insights into the data and highlighted anything I felt was important on the transcript within Microsoft Word so that this could be reflected upon later.

Coding is a process of systematic pattern identification within data (Braun and Clarke, 2021). It is a strategy which is used in a range of qualitative analyses, and not just Reflective TA (Maxwell and Chmiel, 2014). It can be carried out from an inductive or deductive standpoint; that is that it can be driven by the data itself, or it can be driven by prior understanding, such as a researcher's experience or theoretical framework (Braun and Clarke, 2013; 2021). In this instance, inductive coding was utilised. This is because the research questions aimed to understand the experiences and views of the participants, rather than

interpret these through a theoretical lens. Whilst inductive coding is supposed to be derived from the data, qualitative research can never be purely inductive (Braun and Clarke, 2021) as it is the researcher who decides what information is important within the data, and which stories to tell (Fine, 1992).

Coding is rarely concluded the first time (Saldaña, 2013) and there were multiple phases of coding and re-coding in this research. After transcription and familiarisation, all transcripts were uploaded to NVivo and initial coding was undertaken whilst continuing the familiarisation with the data. This led to over 150 distinct codes being identified across the 10 interviews. These codes were reviewed for initial patterns and this information was then used to undertake a further phase of coding where all ten interviews were coded across several subsequent days. This resulted in 42 codes being identified which were then used to generate the initial themes. At this point I exported the codes and associated data to Microsoft Word and started to organise my data in a way that made sense to me. The codes were a combination of semantic and latent codes, combining descriptive meaning which remained close to the language of the participants, and also deeper more implicit meaning from my understanding of their experiences (Braun and Clarke, 2021).

Once my codes were exported to Word, I began to question whether my coding was complete, as I struggled to organise my themes. At this point, around January 2022 I was stuck with a feeling of ‘analysis paralysis’ and how to best represent the experiences of the participants. Gilbert (2002) reports that researchers can fall into a “coding trap” (p.220) whereby there are too many codes and they become stuck with the analysis. It is not unusual for

codes to develop further as the researcher gains more analytic insight into the data (Braun and Clarke, 2021) and when this happens, it can be helpful to move away from the data for a period of time or to print the codes and reorganise them manually (Gibbs, 2014). I allowed myself time away from the material and returned to other aspects of my thesis before deciding to print out the data and physically re-code the information by hand. I found that the time and space served to help me see the data more clearly and that physically seeing the information printed out was a useful exercise.

Developing themes from the data involves a process of exploring areas where there is shared meaning and pulling together codes which are connected to explore meaning patterns (Braun and Clarke, 2021). As outlined above, I had already moved on to developing initial themes before reverting to manual recoding of my data and it was this process of physical recoding and developing initial themes which helped me to move past my mental block. At the end of developing potential themes, I was left with six overarching themes and felt more confident that these were representative of the data and experiences presented by the participants.

At this point, I moved on to review the themes. This stage involves considering the viability of potential themes and exploring whether there are better ways to organise the findings, whilst considering the richness of the information and how it relates to the research question (Braun and Clarke, 2021). It was at this time that I realised my themes still required further development. I felt I had too many themes that were too fragmented, with some areas which required more depth. Whilst I was happy with my coding, I decided to go back to consider my themes overall. Braun and Clarke (2021) describe this phase of

reflexive TA as "*particularly* recursive" (p.97, emphasis as in original) and I went back and forth in this part of my analysis several times before finally deciding on the themes presented within my finding's chapters. Even during the writing stage, I continued to review the themes and decided to combine two, as the writing process helped me see how the two areas were connected. The original two themes in question had focused on the gravity and severity of prebirth work and the complexity of practice in this area. Whilst struggling to articulate a whole theme on the gravity of the work, I realised that this high level of responsibility and the perceived severity of the work were in part contributing to its complexity.

The final themes presented in the thesis are:

- "The unique complexity of pre-birth work"
- "Trying to do the 'right' thing"
- "Wildly underprepared and really scared": Practical and emotional support with pre-birth work

Chapter Summary

This chapter has addressed the methodological assumptions of the study and justified the methods used to conduct the research. The study was qualitative in nature, utilising a critical realist ontological and epistemological position. The data was collected using semi-structured interviews with ten current or ex-social workers who had experience of completing least one pre-birth assessment. The interviews were all transcribed by myself as the research and then analysed using Reflexive Thematic Analysis. This has resulted in

three themes and the following three chapters will explore these findings in detail.

5. Findings Chapter 1: The unique complexity of pre-birth work

5.1. Introduction

This theme draws on participants' views on what makes pre-birth assessments a distinct type of work within child and family social work. Whilst child protection work can always be complex (Munro, 2010; Saltiel, 2016; Walsh, 2006), assessing an unborn baby brings several unique challenges to the process. When asked directly, participants did not necessarily feel that all pre-birth assessments were always more complicated than other work, with Annie reflecting, *"Some of them are pretty straight forward, and some of them are just the most complex pieces of work that you will ever do as a social worker"*. However, even when the situations that led to the assessment did not feel inherently 'complex', there were additional factors that participants discussed that made them feel more challenging. These included the perceived pressure of the assessment work and level of responsibility felt by participants. The invisibility of the unborn child during the assessment was a common thread through some of these challenges, which made the task more complex and ambiguous. Participants questioned where the focus of their assessment should lie and whether the primary client should be viewed as the parents, or the invisible unborn child. Assessing parenting capacity where parents have no prior parenting experience without a child being physically present leads to challenges in decision making, with the need for social work intervention to be based on evidence. Alternatively, assessing parenting capacity where there has been a long history of involvement with services can present challenges in how change can be evidenced for *this* child. Three sub-themes will be

explored; ‘”An ominous pressure”: the weight of the work’, ‘Whose social worker are you anyway?’ and ‘”Educated guesswork”’.

5.2. “An ominous pressure”: the weight of the work

This section explores the weight of pre-birth work and how this differs to other areas of child and family social work. A key reason for this ‘heaviness’ is the potential outcome of a pre-birth assessment being recommendations that the newborn baby may be removed from parents’ care at less than a week old. Participants reflected on how severe this felt, and the heightened responsibility that they felt undertaking the assessments which inform these decisions. Participants discussed empathising with the situation this placed parents in and reflected on the potential lasting impact this could have on both the baby and their parents. Some participants also reflected on how this challenged their views of practice and went against the type of social work they had hoped to be involved in when they made the decision to become a social worker.

Almost all participants spoke about how heavy pre-birth work could feel and whilst they reflected that the outcome of all assessments was not always removal, this possibility weighed on their minds and left them feeling responsible for decisions which could be described as *“catastrophic”, “monumental”, “enormous”, “heavy”, “brutal”* or *“profound”.* These feeling reflected what Bourdieu (2012) identified as ‘social suffering’. That is recognising contradictions between their statutory roles and their obligation to promote social justice (Houston and Swords, 2022). Making decisions around whether to remove a child from a family or leave the child within the family is always difficult, with the potential of harm being caused to the child from a wrong decision (Davidson and Wozner, 2011). Deciding whether to remove an

infant shortly after birth adds an additional layer of complexity as Hodson (2011) explained:

> "Removing a baby at birth brings with it an inevitable impact on the process of attachment and bonding, as well as the impact of subjecting a family to court proceedings and all of the emotions that entails. However, allowing a baby to be discharged from hospital to a family who are unable to provide appropriate care and protection may result in irreparable harm to, or even the death of the baby." (pp.14-15)

Whilst this study was not solely focused on work which resulted in removal, many of the participants were drawn to exploring the examples which resulted in removal. This may be because some of these more difficult experiences have remained with the participants and participating within the research offered them an opportunity that they had not previously been afforded to explore their feelings around this. It is well established in research that emotive experiences are more likely to remain with people than those that elicit less emotion (Kensinger, 2009; Cooper et al., 2019). The removal of infants from their mothers shortly after birth is arguably highly emotive, as Daniel commented, "*it stays with you*". The emotional aspects of the work will be explored further in the final findings chapter (see Chapter 7).

The gravity of the decisions and the participants feelings of responsibility led them to feel pressure in their work. Annie summarised this, explaining:

> *"The potential outcome of any pre-birth assessment is that the baby isn't gonna be with the parents. Erm - and that's just huge. And I can see how huge it is now, like what you said about hindsight and, ah, it's*

massive. You know? Who would have, who, who would've thought that that's even an option in life."

Annie had left social work practice several years earlier after over a decade in practice. At the time of the interview, she had let her registration lapse without renewal. Our discussions prior to this had been reflecting on the similarities in our experiences and seeing things with fresh eyes, after having time and space from front-line practice. This feeling of an *"ominous pressure"* (Daniel) and responsibility was felt by all participants, whatever their level of experience. Harry was a Newly Qualified Social Worker (NQSW) at the time of the interview, and he explained, *"[the] decisions that you're making, and it's the, you know, the - they're huge aren't the'. The implications are massive".* Whilst all participants discussed the weight of the work, some articulated that this is needed due to the level of responsibility that the work brings. Daniel explained, *"It's quite an ominous pressure and I don't think you should feel it any other way, um, whether you're 20 years post qualifying or you're a new first year. I think it should probably feel the same."*

The reasons for this 'heaviness' were varied, with links to the age of the child, the impact of separation on the parents and the baby, and their feelings about removal. All child protection practice can he highly emotional (Caringi et al., 2012; Morrison, 1997). The forced separation of a child from his or her parents can be seen as one of the most challenging and emotive aspects of practice (Mills, 2011, Miranda and Godwin, 2018). Care orders for newborn babies have been described as "extreme" (Juhasz, 2018, p.530) and "invasive" (Skivenes and Søvig, 2017, p.40) within research. Participants in this study felt that removal after birth was one of the worst possible outcomes that could

be enacted within social work, despite recognising that this was sometimes necessary to ensure that the baby was protected. Ella explained, *"Obviously that's horrible for families that is like the worst thing that can happen for a family."* Daniel felt that removal after birth was the most draconian action that the state could take against a person, saying, *"What else is there? But we don't execute people anymore. Removing someone's baby's probably up there is. I can't think of anything more that the state would do in front of your face sort of thing."* These quotes reflect the gravity of the feelings around assessments that can result in removal so early in a child's life, and the potential impact that this can also have on the parents. Whilst pre-birth assessments are multi-agency assessments, like all assessments undertaken by child and family social workers, the LA and its social workers have responsibilities to lead statutory assessment under section 17 Children Act 1989. The Children Act 2004 section 11 placed duties on a range of organisations and agencies to ensure that children are safeguarded and their welfare is promoted, but it is still the social worker who compiles and analyses the information available to put forward decisions about outcomes for children. As has been found in wider literature (see Critchley, 2018b; Ward and Brown, 2010) there was a sense that the participants sometimes felt alone or vulnerable, with Ella expressing "*it's hard, it's a lot to deal with on your shoulders only*".

As has already been touched upon, participant empathy with the experiences of the families was evident throughout their discussions. It was clear that they often tried to think about the experience from the family's perspective, and this positionality contributed to the weight and responsibility that they described. Even though some participants discussed a focus more on the unborn baby

than the parents, which will be explored within the next section of this theme (section 5.3), they still felt a sense of responsibility for the impact on the parents. Harry described this as a challenge to his values, as *"you kind of you want them to stay with family like Mam, dad, but you you obviously you know you've gotta assess risk".*

The age of the baby at the point of intervention also contributed to this and made pre-birth work feel heavier than other child and family work at times. This was both in terms of thinking about severing relationships so early on and considering the vulnerability of infants. Participants also discussed how families would not be able to get to know their child before that relationship is severed and there was an acknowledgement that a removal at this age may be less likely to result in reunification (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Pearson et al., 2020). Jake explained, "Y*ou make an essentially a huge life-changing decision for these family that may result in them, never seein' that child again"*. Isabelle explained this in terms of thinking about the impact on the relationship and attachment between the baby and the parents:

> *"I suppose I'm acutely aware that the pre-birth assessments outcomes are slightly different in that if I remove a child at age 7 from their parents care… there's been a relationship beforehand. At the end of the pre-birth assessment of the decision is that child can't be safely cared for by mum and we remove. Yes, we look at reunification but I – It's what we've done to that relationship and attachment at the start as well um and the timing of which is sometimes parents have only spent 24 to 48 hours with the baby, and then we'll intervening, and it's such a severe level"*

The age of the baby also led to a feeling of additional pressure and responsibility due to the vulnerability and fragility of newborn babies, with many of the participants referring to the babies as “vulnerable”. As Harry explained:

> *“I think when it's a newborn as well, you feel. You just have that responsibility… I think 'cause it was a newborn as well… Depending on [the] age of the child, you’re always going to have concern, but I think for a newborn it's literally kinda, they can’t fend at all for themselves”*

Critchley (2018b; 2020b) identified similar findings in her work exploring pre-birth assessment in Scotland, with an increased anxiety felt by social workers due to the dependency and vulnerability of infants.

All participants reflected that they did not want to remove babies from their families, even though this was part of their job. Not all the participants had been involved in removals following birth, Ella and Harry were both relatively newly qualified and neither had been involved in the removal of babies from their parents. Ella was working with two families where the recommendation of her assessment was removal, and it was clear during the interview that the prospect of this was upsetting for her. All the other participants had been involved in at least one removal shortly after birth. Participants who had been involved in removals, and those who had not, reflected that they really did not want to do this. As Bonnie explained, *“I guess what, what you don’t want to do is you don’t want to remove a baby... Really. And that’s the crux of it. Nobody wants to remove a baby”.* This builds on the current knowledge base outlined in the literature where being involved in the removal of infants shortly after birth

has been described as traumatic, emotionally challenging and distressing for professionals (Everitt et al., 2015; Marsh et al., 2019; Marsh et al., 2020; Powell et al., 2020). There appears to be a lack of wider literature about social workers experiences of being involved in child removal to compare with pre-birth practice which may be an area which warrants further research.

5.3. Whose social worker are you anyway?

As was explored within the last section, participants were aware of the impact and implications of their involvement for both the baby and their families. Participants found different ways of navigating their assessments and dividing their focus; some took a stance that their focus was on the baby and the outcomes for that baby, other felt that this was not appropriate and that the focus should be on the mother until the baby is born. What is clear from the participants is that this division makes practice more complex and can raise ethical dilemmas on who should be perceived as the 'client' during pregnancy, as Chloe explained:

> *"So, I was trying really hard not to bend to my own feelings and to try and manage that and try and balance my sympathy for her, with my prioritising the baby, who wasn't there yet. So that was kind of hard to do"*

In keeping with Critchley's (2018b) findings, whereby the unborn baby was generally the primary focus of social workers in her study, some participants maintained a focus on the unborn baby. Critchley (2018b) reflected that this mirrored the law, whereby the interests of the child are paramount, and that it is the social worker's role to uphold these interests. In England the welfare

principle (Children Act 1989, 1(1)) enshrines in legislation that the child's welfare is paramount and the statutory guidance WTSC (HM Government, 2018) specifies, "Whilst services may be delivered to a parent or carer, the assessment should be focused on the needs of the child and on the impact any services are having on the child" (p.27). Repeatedly, research has found that good assessment should have a central focus on the child (Turney et al., 2011) however this does not account for unborn children who are as yet not physically present. Participants who took this stance mentioned "*duty of care*" towards the child (Harry), "*not losing sight of the end point of… the assessment and what I am trying to achieve*" (Jake) and "*focus[ing] on the impact on the baby*" (Annie), reflecting the language in legislation and guidance. This is not to say that these participants disregarded parents within the process as they all mentioned balancing this with the needs of the parents, but some found it easier to focus primarily on the baby. Some of these participants were very future focused in their views, imagining life for the unborn babies after birth and keeping that at the forefront of their minds. Annie discussed this in detail, making links to some of the families that she worked with. She felt that focussing on the baby above all was a way to deal with the pressure of the assessments:

> *"So at the time, I do think that, that was sort of a, a coping strategy almost… So, that, that's how I saw my role because obviously, you know, legally the unborn baby didn't have any rights or anything like that. Erm (pause – tut) so it was about, sort of protecting, I use it, I always used to think, so when this baby is born and is three weeks old*

> *and in a cot, or a pram in that house, what is it's life experiences going to be like?"*

Jake talked about one pre-birth assessment he had undertaken where he too focused on what her life would be like after birth, "*you build this picture of just how horrendous this life is going to be for this little girl. Um, if she was to remain with these parents*."

As with Critchley's (2018b) findings, this focus on the baby was "at once the object of the practitioners' imaginations yet simultaneously unseen" (p.209) and this may well be due to the shifting focus of child and family social work. As outlined in Chapter 2, The Children Act 1989 repositioned child and family social work from a child welfare approach which focused on the needs of children and the family, to a narrower focus on child protection via surveillance and control which focused on risk (Rogowski, 2015). This shift was influenced by several factors, one key factor being high-profile and public criticisms of social workers and other professionals who have failed to intervene to protect children (Parton, 2011). There are concerns that this way of working focuses too narrowly on the children, whilst seeing the needs of the parents as only secondary (Hearn et al., 2004; Janićijević, 2016; Spratt, 2001). This focus on the unborn babies may be related to the child protection culture of English child and family social work, or it may be related back to the invisibility and vulnerability of the unborn baby. Annie explained:

> *"I always, sort of, had to rationalise it as almost being an advocate for that unborn baby. Rather than (tut – Pause) an advocate for the mother,*

or, family or anything like that because it was, it was the only way I could get my head 'round, what we were actu- the potential outcome"

Not all participants focused so intently on the baby. Chloe talked about feeling conflicted in her focus, and flipping back and forth between a focus on the baby and a focus on the mother as a result of the invisibility of the unborn baby and her empathy with the mother:

"I think in that case I found until [baby] was born, I found it so difficult to think about him as a person. Cause I was constantly just thinking about mum and feeling so awful for mum and how worried I was about her and how sad she was. And then I was feeling bad because I was like, oh, I'm the one doing this to her."

Other participants discussed this struggle, and this appeared to stem from the relationships with parents that were developed over the course of the assessment and the recognition of how difficult this could be for parents. Many of the of the participants reflected on what it must feel like to be a parent being assessed before birth. Daniel explained:

"I couldn't imagine what would be like being an expectant mother if you, if you really weighed it up and think, oh yeah, yeah, I'm going to lose the baby 20 weeks before you're going to give birth. It must be absolutely terrible ordeal"

Bonnie said something similar, *"But can you imagine, but can you imagine getting pregnant getting pregnant and not knowing and having the child removed and not knowing if you'll be able to keep them?".* Ella discussed how

difficult she found the process, and reflected that, *“I can only imagine how much worse that, that is going to be for her.”*

Whilst Chloe discussed a lot of conflict, especially related to one mother and baby when she was relatively newly qualified, she dealt with these feelings by speaking to her manager who encouraged her to think more about the baby than the mother:

> *“Well my, my manager was always like, hang on, you're doing this for the baby. You're not doing it for her. So yeah, it is upsetting for her, but tough shit because actually it's going to be more upsetting for that baby if she drops it on his head or whatever and it dies”*

Chloe believed that she would have approached that same assessment very differently now and that she would have been more inclined to manage her feelings about mum differently, being more “*blunt and firm*” right from the start, which is an aspect that will be explored further within the next findings chapter (Chapter 6). Despite this, it was clear that there was a continued struggle about where the support, assessment and intervention should be focused during her work with unborn babies and their families.

Whilst other participants discussed balancing the needs of the baby with those of the parents, Finlay was the one who felt most strongly that the focus of pre-birth assessments should be not be so keenly focused on the baby. He felt that, *“[Mam’s] are almost taken out of it from the beginning”.* He discussed being very vocal in challenging what he saw as bad practice and reported he had spoken up to managers about what he saw as an injustice. He openly

discussed struggling with pre-birth assessments in the current climate of a child protection, stating:

> *"Um, really struggled with it… and it was very much that the party line, if you like was very much, you need to do what you need to do and it's for the baby. It's not for mam… It's just too clinical, too severed to cut off. Um, the party line always was you're the baby's social worker, the baby's social worker, the baby social worker, and (pause) I think it's quite cruel."*

Finlay's view reflected those who are critical of the current child protection system, as outlined in Chapter. He felt that there needed to be a whole system change, where parents and babies were looked at holistically, moving towards a child welfare approach and away from the child protection approach which arguably dominates practice currently. These ideas will be explored further within the next findings chapter (Chapter 6).

5.4. "Educated guesswork"

Fairburn and Tredinick (1980) raised questions about how it is possible to assess parenting capacity before a child is born, yet over 40 years later many of the participants spoke of the difficulties around trying to predict the future in pre-birth assessment work; something Bonnie labelled as a "*very educated guess*". Social workers work in uncertain terrain (Taylor and White, 2006), where decision making can be "laden with risk and uncertainty" (Budd, 2005, p.429). Determinations often have to be made based on competing versions of events, and where future outcomes may be unpredictable (Budd, 2005; Taylor and White, 2006). The 'right' answer may only be obvious in retrospect

(Taylor and White, 2001), an idea which will be explored in more depth in the next chapter (Chapter 6). Pre-birth assessment offers an additional layer of complexity to this decision-making process, with an unborn infant who is 'invisible' and parents who may have never had the opportunity to evidence their ability to parent. This might be as the unborn baby is their first child, or previous children may have been removed from their care shortly after birth. Alternatively, they may have had experience of parenting, but where there have been concerns about their care of their children which ended in removal. Assessing parenting capacity in any situation can be complex and challenging (Eve et al., 2014). There is no universally accepted standard of parenting and considering the quality of parenting capacity requires the consideration of context, which can be subjective (Whitcombe-Dobbs, 2019). When there are concerns about a child's safety, parenting capacity may be defined as "The ability to parent in a 'good enough' manner long-term" (Conley, 2003, p.16). As has been highlighted earlier within this thesis, pre-birth assessments have additional complexities whereby the child is not present and the relationship between parents and the child is invisible (Hart, 2001). This section will explore how participants navigated this challenge and how it adds to the complexity of pre-birth work.

Some participants joked that being a fortune teller would be helpful, which mirrored my own reflections (see section 1.3), which I wrote prior to undertaking any interviews. Harry pointed out, "*You cannae seen in the future, I suppose. That would make the job a lot easier, wouldn't it? (laughs)*." Jake made a similar comment, "*We haven't got crystal ball and, and, and I sort of think social work isn't a science and I sort of wish it was*". There was a sense

that pre-birth assessment contained many aspects that felt like *“educated guess work”* as Bonnie put it. The participants had between one- and fifteen-years’ experience and yet this feeling spanned the experience spectrum. Harry had just completed his ASYE year at the time of the interview, whereas Jake had been qualified for 7 years. The fact that both participants made reference to fortune telling speaks to the uncertainty felt by social workers assessing unborn babies.

As it is not possible to be able to predict the future, participants spoke of how they navigated this uncertainty. Gabby reflected that being balanced and taking on board what information is available was the only way forward, but this was not perfect:

> *“You know we, we wish we could see what it's going to be like a year down the line, but we can't so kind of being balanced in our decision making and our assessment of what life is going to be like for that baby both when unborn and when born. You just don't know”*

Similarly, Jake later reflected further on the uncertainty and how he managed this:

> *“I can write an assessment. I can have an idea but I've got no guarantees that that's gonna stick. Um, and that's quite hard to think about, I think that there's no certainty. You can only assess what's in front of you. You can only assess based on what has happened and, and hope that this is the right placement for that child.”*

Almost all participants discussed some difficulties with this idea of ‘predicted parenting’ whether families had previously had children or not; although many

participants discussed only having been involved with families where there had been previous children removed. When Chloe was asked if she had ever undertaken a pre-birth assessment with a family who had no previous children, she responded, "*No. That would be really confused. (laughs) I would not know how to do that*" and yet pre-birth assessments are also undertaken for first time parents where there are concerns about parenting capacity. Chloe was not alone in having no experience of assessing first time parents, about half of the participants had only been involved with families when there had been previous removals and yet Hart (2001) found than less than half of the pre-birth assessments she looked at had previous siblings removed. Hart's (2001) research is now over 20 years old, and exploring the contexts that lead to pre-birth assessments may be an area which requires updating in research.

Out of all the participants, only Daniel discussed a strategy for feeling confident in assessing untested parenting;

> *"My cheat to that thought is basically it's a bit, again, it might be a bit glib, but my rule of thumb is you have to have a functioning adult before you have a functioning person for parents, right? So if mam or dad doesn't have the rudiments, which I mean by, has got some understanding [of] their mental health needs, can look after themselves physically their personal care, pay the rent fill a fridge with shopping. That's your starting point because you can't lay parenting on top of the situation if those things aren't happening… I'm assuming it's a cheat, I almost don't have to think about the parent until they've done those things, because I don't believe that you can. (Laughs) Which, which I think it's true, but I think I feel bad saying it again, (laughs)."*

This approach suggests a deterministic view, that having the baby will not have an impact on the parents motivations or abilities, when the arrival of a baby can be a turning points for parents which can bring about change (van Vugt and Versteegh, 2020). This was an interesting point for Daniel to make alongside the rest of the interview, as he was passionate about social justice and felt that there were several systemic and cultural difficulties with pre-birth assessment work, which will be explored in the next findings chapters (Chapter 6).

The 'educated guesswork' of pre-birth assessment can also be heavily influenced by previous involvement with the family, colouring the involvement with the current baby. Annie mocked that this history could sometimes influence decisions and guide the assessment from the point of referral, *"I remember other people in the team having ones where you know, like the history was almost making the decision before they even, you know had sex almost."* What Annie was alluding to here was the idea that some families had such a significant and lengthy history of involvement, sometimes with multiple instances of child removal, that the assessment could feel futile. The practical aspects of this will be explored further within the next chapter (Chapter 6), with this section focusing on how this can make the assessment task more complex. The question about the influence of past harm on future parenting has been asked since the first piece of research looked at pre-birth assessment, with Fairburn and Tredinnick (1980) questioning, "With what accuracy can one extrapolate disturbed and damaging behaviour towards an earlier child to that with subsequent babies?" (p.990). The analysis of previous involvement with any family is an important aspect of any social work

assessment, and past behaviour has been argued to be the best predictor of future behaviour (Forrester, 2004; Munro, 2008). However, the question of what weight to give this previous involvement caused conflict for the participants. Harry explained:

> *"You've got to look at the past because it can predict the future… what do we then say for something that happened 10 years ago? Yes, we gotta take that into consideration. But then is that gonna then determine, you know, what happens now?"*

When dealing with children who are physically present the questions on how much weight to give the history of a family would remain, but social workers would be able to undertake direct work with the children, observe and speak to them, providing more current information to balance it with. Part of the complexity of balancing past harm and future risk within pre-birth practice appears to stem from the invisibility of the child and the untested nature of parenting for *this* baby. Chloe discussed this distinction:

> *"Like with other C[hildren] and F[amilies] assessments, I feel like, (pause) you know how to get all that information naturally because you talked to mum and you talked to dad or whoever, you talked to the child, you just get to know the child and then you just write about the child. I'm like this child was actually inside their uterus. I can't see it."*

Bonnie also compared how it is different to working with older children, explaining, *"When children are older, they have a view and they have a voice. And so there's other evidence that you can see, and that you can hear."* There was a sense that not having a child in front of you could lead to assessments

being "*more hazy"* as Chloe put it. The concept of 'invisibility' in child and family social work is not confined to unborn babies. Repeated findings from reviews where children have died or been seriously harmed have identified that children can become invisible during social work intervention (Bastian, 2020; Ferguson, 2017). Whilst more severe cases often represent the exception rather than the rule (Cooper, 2005), studies which have explored every day practice have also found that the children sometimes remain invisible during assessment and intervention (Buckley, 2003; Ferguson, 2017). What is different in the case of pre-birth assessment is that the children are physically invisible until they are born, and the assessments and decisions about their future need to be made during this period of physical invisibility. This invisibility sometimes led participants to question their practice, as evidencing harm when the baby is unseen can be challenging. Ella explained:

> *"You can see the impact of neglect or you can see, the impact of being exposed to domestic abuse and drug abuse in the home is whereas for a new born baby. You can't, yeah. You can't see that straight away. Um, so I think if anything it probably makes you question, have I made the right decision?"*

Gabby made a similar comment, explaining, "*I think because we just can't physically see them, we think. We, you sort of sometimes doubt ourselves".* This additional layer of uncertainty that is created by the invisibility of the child appeared to add to the conflict that participants felt about making decisions regarding the unborn child's future before they are born.

5.5. Chapter summary and analysis

This chapter has highlighted the complex and distinctive nature of pre-birth assessment work with families. It has identified many factors that make pre-birth work a unique and highly challenging area of child and family social work.

Foremost was the pressure that is felt by the social workers undertaking pre-birth assessments. The language that they used to describe this experience was highly emotive, with words such as ‘brutal’, ‘profound’, ‘weighty’, ‘heavy’, ‘unimaginable’, horrific’, ‘catastrophic’, ‘severe’, ‘tragic’ and ‘horrendous’ describing the work and the situation for the families. This led to high levels of pressure being felt by social workers in this study, alongside a view that it was their weight to bear, and their responsibility to get right. Whilst participants were unaware of research which considered how unlikely reunification is following infant removal (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Pearson et al., 2020), they saw their decisions as being final and having a lasting impact on the trajectory of both the baby and the parents’ lives. This added to the sense of responsibility and pressure felt by all participants. Many of the participants reflected on the extreme nature of removal shortly after birth and how this felt at odds with what drew them to social work in the first place; a desire to do good (Cree and Davis, 2007).

The participants struggled with how to align themselves with the family in this process, when they were aware of the potential impact of their involvement on the family. Balancing the fragility and vulnerability of a newborn baby with their empathy and desire to support parents was difficult to navigate. Even the prospect of removal of a newborn baby shortly after birth was described as highly emotional and difficult by all participants; whether they had been

involved in this or not. The significant emotional toll of the work on participants is evident within this chapter, however it is also discussed throughout all three findings chapters. This emotionality is further analysed in the final findings chapter which focuses on how social workers are supported to manage these emotions and the impact that this can have on them (see Chapter 7).

All of this conflict and pressure was being felt in a context of uncertainty. With no way to predict the future and no crystal ball to consult, participants discussed their discomfort with having to make potentially catastrophic decisions, with essential elements of their assessment missing. The invisibility of the unborn child throughout the assessment was a key contribution to this discomfort. This meant that the voice of the child was absent from the assessment work, with any evaluation of parenting capacity or ability not being based on observation or evidence and feeling "*more hazy*" (Chloe) than any other assessment. The stage of the participants' careers appeared to have no impact on this feeling of uncertainty and many participants spoke of how this led them to doubt their decision making.

This uncertainty also left space for the history of families to take centre stage during the assessment when many other factors were missing, which brings a potential for risk aversion. At the opposite end of the spectrum, first time parents had no history to fall back on; no prior protective factors nor risk factors to consider as a starting point for an assessment. This left some participants confused as they had never completed a pre-birth assessment for a first-born child, yet the literature identifies that as many as half of all pre-birth assessments are first born children (Broadhurst et al., 2018). The idea of what weight to give past assessments, or what to do when there is no history to take

into account, is discussed further in the next chapter as some participants felt the culture of their organisation had an impact on what weight this information was given that sometimes felt outside of their control.

The juxtaposition of the uncertainty in the assessment process with the finality and gravity of the decisions being made is a highly concerning finding, which extends current thinking on pre-birth social work. Removal of infants shortly after birth has been criticised internationally (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Pearson et al., 2020) yet the findings of this chapter alone raise questions about the ethical and moral basis for these decisions when the evidence can be so unreliable.

Throughout the data collection and analysis, what struck me was the contrast between how the participants responded directly to the question of whether pre-birth work was a complex area of practice, compared to what they went on to tell me. The overriding conscious view of participants was that all pre-birth work had the potential to be complex, but that this was not always the case, with some decisions being easier than others. It seemed there had to be a specific factor within the family or situation for participants to recognise the work as more complex. Most participants discussed how pre-birth assessment work felt ‘different’ to other areas of practice, but not necessarily more complex, which will be explored further in the final findings chapter (see Chapter 7). What the participants appeared oblivious to, at least at first, was all the ways that pre-birth practice is *intrinsically* complex. Yet, this came across very clearly during the analysis, with all participants commenting on how the work posed unique challenges not found in other areas of child and family social work. Often participants also started to reflect during interviews

on how they had underestimated the complexity of the work, or not been afforded the time to think about pre-birth work in general before. This may be indicative of a ‘taken-for-granted’ attitude towards pre-birth assessment, a view that it is a routine aspect of child and family social work; an idea which is explored further within later findings chapters.

This first findings chapter sets the scene for the two remaining findings chapters. It has posited pre-birth practice as a highly challenging, emotive, pressured and uncertain area of child and family social work. The next chapter will discuss how the participants navigated some of these obstacles as individual practitioners, as well as considering the broader cultural and systemic factors that impacted on their ability to do what they felt was ‘right’.

6. Findings Chapter 2: Trying to do the 'right' thing

6.1. Introduction

This theme explores participants' views on trying to ensure that their practice, assessments, decision-making and outcomes were 'right'. As has been explored in the previous chapter, the decision-making process during pre-birth assessments weighed heavily on the participants, where the potential outcome of a 'wrong' decision could be catastrophic (Hodson, 2011).

I had originally thought that this theme would only encompass individual social worker's actions and their feelings of responsibility around getting the outcome 'right'. During the analysis I realised that this process extended far beyond this. Whilst all participants discussed personal and professional conflict in getting it 'right' on an individual level, most of the participants discussed some level of struggle with doing practice 'right' because of the barriers caused by processes and cultures of practice that they experienced within pre-birth social work, a factor which has been evident in wider child protection literature (Samsonsen and Williumsen, 2014). Identifying the 'right' course of action in social work is highly complex with many intertwined factors which operate on various levels (Mänttäri-van der Kuip, 2020). Given the severity and potential consequences of the decisions made before birth, participants discussed wanting to make sure these decisions were 'right' but there was acknowledgement that this was sometimes outside of their control; dependent on other professionals, resources, time and funding. Much of the discussion within this chapter relates back to Chapter 2 and the wider social, political and economic context of child and family social work, that pre-birth assessment operates within. With this complexity in mind, Thompson's (2021) PCS model

proved useful in considering the participants' struggle to get things right from a personal, cultural and structural perspective. This model is used to structure the sub-themes of this chapter, with sections on 'Getting it right on an individual level', 'The impact of organisational culture' and 'Swimming against the tide: the influence of the system'.

6.2. Getting it 'right' on an individual level

As explored in the previous chapter, the decisions within pre-birth practice weighed heavily on participants, with pressure and responsibility looming over their work with families. They took this responsibility very seriously and felt as though the families should be afforded every opportunity possible to make sure that they were able to care for their babies once they were born. There were barriers to this, but many of these operated at the cultural and systemic levels, rather than at an individual level and will be explored later within this theme (sections 6.3 and 6.4). Getting it 'right' on a personal level included doing a thorough assessment, developing strong and balanced relationships with families which are based on honesty, and maintaining hope and belief in people's capacity to change.

One of the things that participants felt was key to getting it 'right' was ensuring that they had given the assessment the time and space that it deserved, and that they had a thorough and detailed understanding of the situations before reaching any decision. Assessment offers a way of gathering information (Kirton, 2009) which is key to making decisions about effective intervention and improving outcomes for children (Turney et al., 2011). Assessment is a complex area of practice (Holland, 2010) and within pre-birth practice, both the literature review and other findings chapters have described some of the

additional complexities that assessing an unborn baby brings. Annie spoke about doing a 'good assessment' as a way of ensuring that the right decisions were being made about the family. She spoke of two families who had very different situations, but where the thoroughness of her assessment led to her feeling more confident that she was proposing the right outcomes for both infants. Talking about one family, she said:

> *"It felt good because I felt I'd thoroughly, it felt like a good assessment. Not in terms of outcomes, but in terms of quality of it… I felt I'd been able to really thoroughly assess it and consider all the risks."*

This involved time, and participants all spoke about trying to ensure that they were able to spend sufficient time with families to understand the situation, including any potential risks and strengths. For Bonnie, this was the crux of *"being a good social worker".* Whatever the outcome of the assessment was, she felt that there had to have been a thorough and detailed outcome which led to a conclusion which was "*absolutely the right thing"* for that baby. She recognised that it was not always this simple, and that doubts and mistakes were natural:

> *"I think because, as a social worker, you do, you do, you do make bad decisions. There's time where, you know, you do an assessment, you think people are safe and two months later a referral will come back in with lots more evidence. And you think, 'shit I missed it'."*

The key to making the right decision at the time for Bonnie was that *"if you had to do it again, you'd do it the same";* there was strength in your conviction that it was the right things to do, based on the information you had at that time.

This relates back to some of the discussion from the first findings chapter, where participants discussed wishing there was a way to predict the future. Often in social work the 'rightness' of any decision may only be clear in retrospect (Taylor and White, 2001) and what is important is that social workers consider alternative actions and maintain a sense of 'respectful uncertainty' (Taylor and White, 2006).

To be able to do a thorough assessment, almost all of the participants spoke about the need to build positive working relationships with families. Isabelle explained, "*actually I think just getting the basics right and being so focused on that relationship, I think makes a big difference*", and Gabby mirrored this, stating, "*You need to build that relationship*". Relationships have always been seen as key to good social work practice, however, as was outlined in Chapter 2, movement towards a child protection system which focuses on risk and prioritising the gathering of information has overshadowed this in practice (Davies and Collings, 2008). Despite this, most participants in this study spoke very passionately about the relationships they developed with families, even when these were difficult to navigate. Ferguson et al. (2022) argue that it is "the *kind* of relationship involved that matters" (p.222, emphasis as in original) and participants in this study spoke of strong working relationships, that balanced honesty and empathy and closeness with objectivity, often being key to them doing pre-birth social work the 'right' way.

Mirroring my own experiences, many of the participants spoke fondly of their work with families and felt that the relationships with parents were some of the proudest aspects of their work. Almost all participants had examples of practise that they could not help but smile about when they discussed, and it

was often the relationships that they felt had been key in these examples. On a more practical level, relationships were seen as tools necessary to successful engagement and to support families effectively. Jake talked about the relationship as a tool that supported openness and provided a basis for future work, whatever the outcome:

> *"I think, um, you know when you're build that relationship with the parents, and then you're able to have those difficult conversations with them, you know, if, if, if the outcome of that isn't right, and then, you know, then it's, it's the work after that assessment that needs your relationship with them to, to be strong enough to carry that forward."*

As Jake alludes to here, the reason that the relationships were key was the need to address power and be able to have frank conversations about the potential outcomes of the assessments, even when these plans go against what the family want to happen. Building these relationships involves balancing rapport-building with objectivity, as Annie explained:

> *"You had to be able to support them during, through that process, whilst maintaining sort of impartiality, or ju-, everything just had to be so balanced. It was always a, I mean all assessments are a bit of a balancing game aren't they"*

Child protection social work has been referred to as a "balancing act" (Kettle, 2018, p.19) and one of the things that Kettle (2018) feels is key to this balance is the closeness and distance between the family and the social worker. That is having to maintain enough of a distance to remain professional and

objective, whilst remaining close enough to build positive working relationships.

Honesty was seen to be key to building these strong and effective working relationships, as has been found more widely in child protection practice (Kettle, 2018). Bonnie spoke at length about a pre-birth assessment she undertook as a student social worker, where there was "*no smoke and mirrors*". She spoke about being honest with the mother about the potential outcomes from the first meeting, and that this honesty and clarity was what made it work so well, despite the plan being for the baby to be removed after birth, *"it felt like a really good piece of work 'cause it very clear, she, she felt supported, she knew what the decision was and we just worked together".* Bonnie explained this level of honesty and the relationship she developed with the mother helped the mother to come to terms with the reality that she was not yet in a place where she could safely care for her baby. Having a structured plan and high levels of support allowed the mother to work with professionals to ultimately have the baby returned to her care, but Bonnie felt her honesty and relationship had helped make this possible. Jake also discussed the importance of honesty as a way to address the power dynamics of the relationship:

> *"I tried to, um, make them aware a little bit about my thinking throughout. So what I don't like to ever do is get to the end of an assessment and my conclusion be a surprise to people… It's not always the easiest thing in the world to do, and I always had to families, you know, we're not always gonna agree on things and that's okay."*

As Jake mentions, being this honest was not an easy thing to do all the time, due to the severity of the possible outcomes. Some participants talked about how the relationships could be irrevocably damaged by what the family perceive as dishonesty or deception. As Bonnie explained, *"If they are surprised by something or they don't get what they want, that can then taint the whole, the whole thing."* Bonnie was talking about an experience whereby her plan was changed, explored further within the next section, (6.3) however other participants also discussed the potentially negative impact of not being upfront from the start. Chloe spoke about struggling with honesty around the potential outcome of pre-birth work when she was relatively newly qualified. She described her work with one mother where she felt that she had not been as honest and upfront as she could have been, due to her worries about the mother disengaging and because she did not want to cause her undue distress. Reflecting on her approach she felt this may have given the mother false hope about caring for her baby after birth, when the outcome of the assessment was to seek a Care Order once the baby was born. This experience had an impact on how she has approached subsequent pre-birth work in a 'blunter' fashion from the start:

> *"I would always like, I would always introduce the worst case scenario. So parents know what the stakes are because otherwise they might walk into it, not understanding how serious things are… They need to know where the goalposts are. So I like always lay it out really clearly. Like, you know, here's child in need here's child protection, here's PLO. Here's what would lead us to wanting to remove your baby. This is where we are with you right now because of X, Y, Z. Like, what are the*

kinds of things we need to do to make sure it never goes any higher and come back down. Yeah. That's really important."

Honesty and transparency is seen as a key contributing factor to relationship building and effective engagement within the wider child protection literature (Gallagher et al., 2011; Toros et al., 2018). It is also something that families want (Spratt and Callan, 2004; Toros et al., 2018) and that social workers see as important (Gallagher et al., 2011). Within the literature on pre-birth practice, honesty has also been highlighted as key, with both families and professionals reporting it is needed to develop positive working relationships (Cox et al., 2017; Hard, 2002; Lushey et al., 2017; Mc Elhinney et al., 2021; Ward et al., 2010). For Chloe, she reflected that her lack of an upfront and transparent approach was damaging to the relationship and caused distress for the mother and for her during that period. Being honest about the potential outcome of any assessment may be challenging, as with Chloe's experience, social workers may worry about families disengaging with the assessment or causing families to worry. For pre-birth assessment in particular some participants raised concerns about the impact of stress on the mother and the baby, and this might contribute to a resistance in being upfront about the reality of the potential outcomes of the assessment. Harry explained, *"you know you gotta consider mam's heavily pregnant... There's the stress of different services being involved, a stress of obviously child protection planning, PLO…".* Annie undertook a pre-birth assessment with a mother who had a stillbirth later in the pregnancy and an inquiry was undertaken to consider whether the stress of the assessment and ongoing multi-agency involvement had contributed to the loss. Whilst the conclusion was that the reasons for the loss of the baby were

medical, Annie said "*You know, those kind of thoughts went through your mind".* These points highlight how challenging it can be for social workers to have such frank discussions, while also considering the stress that this will cause.

Another factor which impacted on relationships was the pre-conceived ideas that families had about social workers. This could be about the negative views of social workers as being either overly intrusive or too lenient which have been highlighted in wider literature and explored in Chapter 2, as Jake explained:

> *"I think perceptions of social workers isn't always helpful… you're already coming at it from a weird power imbalance. Um, you know, uh, parents believe that social workers are there to punish the families that are, that are innocent and, and sort of let off the family down the street that was smoking heroin in the front garden… that's a really difficult perception to, to work through in the timeframe of an assessment."*

For pre-birth assessment in particular there was also the added complexity of families who have had previous children removed. As Ella explained:

> *"I found as well that you're going into a situation where if social workers have removed children in the past, um, then (pause) they're quite hostile (laughs) towards you... So it can take a while to build up that relationship at the start and, um, and get any engagement as well. I've found that they're more likely to be the families that don't answer the phone calls, don't answer the door"*

Parents in Mason et al.'s (2022a) study wanted professionals to appreciate how difficult it can be for them to trust professionals when they had had previous negative experiences with social workers. Chapter 2 also highlighted the role of the media in creating moral panic and influencing the public perception of social workers, which undoubtedly can affect parents' view of the role social workers play. Again, participants discussed the role of honesty and also authenticity in trying to build relationships quickly and navigate the challenges of preconceptions. Finlay discussed taking an approach where he dealt with this openly:

> *"They've all got so many stories to tell about horrendous, horrendous social workers have been and how horrendous their childhoods were, but, and I never ever would challenge or defend that. But what I always used to say to people is can you please take me at face value? And don't judge me based on your experience with social workers in the past. And I'll offer the same to you… Um, and that used to work quite well. And I enjoyed that."*

Regardless of the situation of families, participants were all very clear that there had to be hope in the assessments in order to feel as though they were doing the work 'right', and that families had to be given every opportunity to provide evidence of change. As Daniel explained:

> *"If you can't give them a chance then what's the point, you might as well just tell them to get an abortion. Do you know what I mean? It's like, you know, you're removing someone's child, you've got to give them every single chance and support possible to do different."*

This belief that parents have the capacity to change was mirrored through the way that participants spoke about their individual work with families. Finlay went on to add, explaining, *“If we don't believe that people have the capacity change, then we may as well just all pack our stuff up and you know, surely that's the foundation of why we do what we do”.*

On an individual level, the foundational values of social work were evident in the participants discussions. In a wider context of concerns about risk averse practice in child and family social work (Featherstone et al., 2016; Hardy, 2020; Parton, 2014; Warner, 2015) and specifically within pre-birth practice (Critchley, 2018b; 2020a), the participants all discussed wanting to spend time building positive working relationships where they could be honest and challenging in a supportive way that gave parents the best possible chance of evidencing they could safely care for the baby after birth. The challenges to this were described at organisational and systemic levels, which will be explored within the next two sections of this chapter.

6.3. The influence of organisational culture

Whilst participants spoke of doing what they could to ensure the quality of their own practice, they also discussed how cultures within the organisations they worked for impacted on their ability to make the ‘right’ decision or take the ‘right’ actions for the families and babies they worked with. Organisational culture can be defined as, “taken for granted basic assumptions held by the members of [a] group or organisation” (Schein, 2004, p.22). This can include shared values, beliefs and assumptions which influence how an organisation and its members think and feel (Drumm, 2012). The discussions around organisational culture fell into two broad areas; control and time. Some

participants spoke of how they felt their assessments and decisions were not their own, and how organisational culture could push them towards outcomes they did not agree with. Many participants discussed the influence of time and how this is used within organisations, with teams' cultural practices not making full use of the time available and pre-birth assessments sometimes not being seen as a priority.

Some participants felt that they were not fully in control of their own practice related to pre-birth assessment. Not all participants felt conflict about these issues and some sought solace that ultimately the decisions were out of their control, seeing this as a way of managing the uncertainty and pressure outlined in the previous chapter. Others found the cultures of practice in their teams to be oppressive, leaving them feeling powerless to do the 'right' thing with the families they were working with. One of the first barriers that some participants discussed was the history of families having such a heavy influence on their assessments. This was explored as a factor which adds complexity to pre-birth assessment work in the first findings chapter (Chapter 5) and here the discussion will centre around how this influenced participant's ability to enact the outcome they felt was 'right' for the unborn children they were assessing.

As has been discussed earlier, some participants felt that decisions could be made at the point of referral into the LA. They felt that trying to change the views of professionals, both within the team and within the wider multi-agency team, was impossible. Annie discussed her experiences of managers making snap decisions at the point of referral. She explained:

> *"Managers (laughs) often make a decision about outcomes at the point of referral… And regardless if the assessment has a different outcome or not, trying to get them to think in a different way is by, nigh-on-impossible… There was a couple of times it felt like, why did I even bother doing an assessment because any kind of chink of potential change, they're not gonna accept that."*

Bonnie had experienced something similar and this had led to her feeling very conflicted in her role. In one instance she spoke about working with a mother whose older children had been removed from her care some years earlier, and some of her colleagues had been involved with the family at this time. She felt their experiences seemed to "*colour everything"* and that they had been left with a *"fixed view"* of this mothers' parenting capacity, due to the emotional nature of the work a number of years earlier. Several years had passed since the older children had been placed in care and the mother was in a new relationship by the time Bonnie met her. After the first meeting Bonnie felt quite positive about the potential safety of the baby within the family. She explained:

> *"I felt that I could see, you know, still quite a young woman who had (pause) had a real, a really tricky life and upbringing and who'd been, who'd been manipulated herself. And actually I could see it, even at that first visit. And I think you do, you get a feel, you don't know everything at that first visit but that first visit was always the absolute crux."*

Following this first meeting, Bonnie had several colleagues approach her to talk about the mother, indicating that there was no way that the baby could remain in her care. This included managers and Independent Reviewing

Officers (IROs), who Bonnie saw as more influential or powerful than herself in terms of the decision making. As a result of this, she felt that the assessment was almost futile:

> *"So that initial meeting felt positive and I think straight away professionals were like, "Ah ah you've been, you know, you've been fooled. You've been fooled. This isn't, this isn't gonna end well. You know, this baby will have to…" And It's almost the decision was made at first contact. You know, it was almost set there. It didn't matter what I was going to do in my pre-birth."*

The experience made Bonnie question how a fair and balanced assessment could ever be completed within the team, and she began to question her other work and the influence of the culture she was working within which she felt made her more cynical. When another mother she was working with commented that she was going to move to another LA where she might be able to have an opportunity to care for a future baby, although Bonnie did not voice her views, she did not disagree with the sentiment; *"And I thought, fair enough. I thought, I almost like felt like telling her to do that. Just get yourself, just get yourself to a new local authority. Where somebody can see it fresh."* Finlay talked about hearing pre-judgement of families in practice and felt that this was evidence of a dangerous and toxic culture in the LA he worked in:

> *"Like some people get cold don't they. And it's like, "ah, this one you can tell what's happening with this one". "Oh, they're so and so's, you know, the Smiths, the so-and-so oh yeah. I had her sister. Oh, this one's*

definitely -" and I think not appropriate and quite dangerous… And I hated that, hearing comments like that."

This is in direct contrast to the feeling expressed within the previous section, where participants felt that there needed to be optimism and a belief in people's capacity to change, otherwise "*what's the point*", as Daniel put it.

Whilst many participants felt uncomfortable with the loss of control, some participants discussed taking comfort from the decisions being taken out of their hands. The upward delegation of decision making is a common social defence for professionals to reduce their own anxiety by pushing tasks up the hierarchy to their superiors (Lyth, 1988; Whittaker, 2011). Chloe talked about not feeling confident in her decision making and relinquishing control to her managers whilst being relatively newly qualified:

"I think by that point I felt like, you know what? I actually don't know what I'm doing. I'm going to take my hands off the reins and I'm going to trust my ATM (Assistant Team Manager) and my TM (Team Manager) because they are very confident that is the right course of action"

Whilst Chloe felt much better about this approach of trusting her managers and reflected this may have been in part due to her lack of experience, other participants felt the culture around decision making left them powerless and ultimately contributed to them experiencing high levels of stress and leaving their posts. This was especially strong for Annie and Bonnie who both felt they were being forced to make decisions that they did not agree with because of the culture within their organisations, which ultimately caused irreparable

damage to how they viewed their roles. Whittaker (2011) reflected that in child protection practice, more experienced practitioners are less likely to use upward delegation as it does not serve to reduce their anxiety. With more experienced practitioners, it is being able to follow their own judgement that reduces feelings of conflict and anxiety (Whittaker, 2011). For both Bonnie and Annie, being unable to enact the outcome they felt was 'right' left them feeling conflicted and they found this difficult to manage; Annie explained, *"Things start to conflict within you. I think once that's happened once, it changes it all."*

For Bonnie, at the conclusion of her pre-birth assessment with the mother who had older children removed several years earlier, she was asked to change her plan from recommending that the baby remain in the care of the parents. This had a profound impact on her, she recalled, *"That was the one that tipped me over… at that point I knew I was out of social work, I was out of child protection."* She felt so strongly that removal was the wrong thing to do that she refused to change the plan and tried to argue her case. When she realised she was not able to do this she explained, *"So the only thing you could do is step away and say, well, I'm not doing this… This will not have my name on."* The work was reallocated to another social worker and Bonnie left her role, although she continued to practice social work in a different area of child and family services. Bonnie discussed feeling very unsupported and vulnerable during this time, explored further in the final findings chapters (Chapter 7). Annie had a similar experience of being made to change a plan. She had wanted to recommend a placement in a mother-and-baby setting to provide further assessment of a first-time mother's parenting capacity, but her managers wanted the recommendation to be removal. Annie recalled how

uneasy this made her feel and talked about presenting the plan for removal in court after the baby was born. She recalled, *"I hope the judge and the sort of other barristers realise that these decisions are actually made at manager level, they are not made at social work level."* To try and regain some control over her own assessment, she refused to change the outcome of her assessment, even though the court papers were changed. She explained that she felt she needed to do this to evidence to the baby in the future that she had tried to argue for what she felt was the right thing to do, despite the pressure to change the plan.

Although Annie and Bonnie found ways to regain some control over their situation, being blocked from being able to do what they thought was 'right' by other factors could be argued to have led to moral distress for them both. Moral distress was first developed in nursing literature (Weinberg, 2009) and was defined by Jameton (1984) as, "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p.6). Experiencing moral distress can lead to a range of negative psychological and physiological symptoms (Hanna, 2004; Wiegand and Funk, 2012). Social workers experiencing moral distress are also more likely to leave their roles (Mänttäri-van der Kuip, 2016) as highlighted by Annie and Bonnie's experiences.

Ultimately, the families in the examples that Annie and Bonnie talked about both ended up with the outcomes that they had originally wanted to put forward. The baby Bonnie worked with was removed from the family after birth but later placed back in their parents' care. The Judge in the care proceedings for the baby in Annie's example disagreed with the care plan recommending

removal and ordered the LA to identify a mother and baby placement instead. Whilst both Annie and Bonnie felt relieved that others finally saw what they saw, by this point they both felt disillusioned with the work and felt that they could no longer continue with their roles. For them, the decisions that were made after their involvement further solidified their view that the issues were cultural and organisational and that the 'wrong' outcome for these families had been pursued, despite their protest.

'Moral distress can lead to professional dissent (Cowley, 2020) and Annie and Bonnie could be considered to have used professional dissent as a way of responding to how they were feeling and gaining some control back over the situations. Professional dissent refers to the range of disagreements that can exist in practice and can span from conscientious objection to disagreement and challenge between professionals (Cowley, 2020). Conscientious objection is the refusal to participate in an activity that an individual sees as incompatible with their own beliefs, for moral, philosophical, religious or ethical reasons (Chavkin et al., 2013). Whilst originating from the military, it has been applied in a range of ethically complex and contested areas (Chavkin, Leitman and Polin, 2013) and is a concept often discussed in health care, especially around healthcare professionals' refusal to perform lawful services based on their own beliefs (Cowley, 2020). Conscientious objection is not a concept that is often discussed for social work, partly due to the ethical underpinnings of social work arguing the values of the profession need to be upheld (Mongan, 2018) rather than the values of individual social workers. Despite this, personal values cannot be disregarded and it is acknowledged that they will shape decision making (Beckett and Maynard, 2013). For Annie and Bonnie, they were not

displaying conscientious objection but professional dissent, as they did not wholly disagree with pre-birth assessments, it was just the instances where they believed the 'wrong' outcome was being pursued. Both used open protest as a way of managing the moral distress they were experiencing.

An additional organisational factor that presented within the findings was time. Time within pre-birth assessment work is felt in an unusual way. There was a sense from the participants that they simultaneously had time and did not have time; whilst they had time with the family to prepare for the birth of the child, this time was often constrained by other factors. Not having a child present that required any immediate action to ensure their safety allowed a sense that there was more time to do the work, although this brought its own challenges which were explored within the first findings chapter (Chapter 5). This "*breathing space"* as Chloe put it, means that you have the time and space to carry out an assessment, to build relationships and to work with families towards mitigating any concerns or risks about the unborn baby. There was time to undertake a thorough assessment which all participants felt was an important factor for them as individual social workers, as highlighted in the last section. Daniel explained, "*It's the one thing in social work where this predictable thing's coming*" and being aware of this means that it can be planned for.

All of the participants who raised the issue of time argued for starting pre-birth assessments as early as possible, *"being able to spend that time with the family… to try and put in support from quite early on"* as Ella explained. Time was seen as valuable in being able to understand the family situation early on and ensure guidance and intervention are put in place and reviewed long

before the baby is born. Isabelle referred to it as a, *"Window of opportunity to enable there to be a period of time to change*" and Chloe explained it as, *"A time period to kind of get things sorted and settled".*

Some participants talked about good practice within the LAs they worked in whereby pre-birth assessments were initiated early, but almost all discussed significant concerns over how time was used, even when policy recommended early referral and assessment. As explored within the literature review, statutory guidance in England gives no advice relating to pre-birth assessments or child protection processes before birth, other than to recognise that a child protection conference may be held before birth (HM Government, 2018) resulting in practice and procedures varying greatly across the country (Lushey et al., 2017). The literature review also explored concerns about how pre-birth assessments may not be prioritised and undertaken in a timely manner (Critchley, 2018b; Hart, 2001; Hodson, 2011; Lushey et al., 2017), and similar concerns were raised by the participants of this study. The findings of this study differ somewhat from the previous research in that the previous studies have attributed this delay to individual practice decisions, rather than organisational or cultural factors. All of the participants in this study who discussed time wanted to start assessments early as they felt this was the 'right' thing to do. However, many felt constrained by organisational factors such as procedures and the lack of urgency within other teams involved in the process. This difference could be due to using volunteer sampling, with participants having more of a vested interest in pre-birth practice but it offers an alternative perspective on the delays in pre-birth assessment work.

Participants discussed not having enough time to do pre-birth work due to procedural timescales and requirements, and the complexity of the work. Many of the participants talked about delays in referrals or families being transferred to teams late in the pregnancy with very little work having been done, even if their organisational procedures promoted early referrals and engagement. Finlay worked with one mother where he felt strongly that she and her baby had been failed by the delays caused by LA he worked within not prioritising pre-birth work. The unborn baby was transferred to him when the mother was seven and a half months pregnant having been allocated to another social worker in another team from early in the pregnancy. There had been no assessment or intervention work undertaken, and there was no plan in place at the point of transfer:

> *"I didn't feel like I had enough time to do that assessment I'd I couldn't, really be able to build the relationship…. I really struggled with how much I felt she'd been failed by the local authority at large… to receive that at seven and a half months, when mam really could have gone into labour at any time, she was in her third trimester. And I thought that was pretty unforgivable to be honest"*

He had felt so strongly about this being wrong that he met with the previous social worker to discuss what had been done, and when he realised that it was almost nothing, he complained to senior management. He did not feel that his complaint made any difference and attributed the delay as being part of the culture of the LA. Whilst this one mother stuck in his mind, he said it was not unusual to have pregnant mothers without assessments or plans in place during the third trimester. Bonnie also raised concerns about late referrals,

saying, "*quite often with pre-births you're working, you know maybe your working within the last 10 weeks. Maybe you know this doesn't come in until 28-30 weeks*." She felt that when referrals were received so late that there was a tendency to be risk averse in decision making and felt this was at least in part to the processes of organisations and timescales for formal meetings where decisions are made. Mason et al. (2022a) found that delayed referrals were a cross-cutting challenge in the eight LAs that they studied. They found that this resulted in too much weight being given to the past histories of families as there was little time to evidence parents' capacity to change, which relates back to the worries raised by participants about the weight given to historical information in the first half of this section.

Participants recognised that there would sometimes be delays in referrals but there was an overarching sense of frustration that often the delays were procedural or cultural rather than anything else. This caused additional stress on top of what was already a short timescale during pregnancy to try and get the outcome 'right' for the family. As Daniel explained, "*You probably don't have many second chances in a pre-birth assessment*" and these additional delays played on almost all participants minds. Many participants talked about quite rigid deadlines within their LA for when strategy meetings and ICPCs should be held, and whilst these offered some guidance and standardisation, there was a worry that this could be too structured. Daniel explained:

> *"You can fall into a trap of doing it like erm you're just churning machines. We started this week, they have three conferences before the birth and this is how we do it. And that, and that lack of, um, lack of flexibility. I think that'll never work for anybody really. Um, particularly*

not now I feel, and I've seen, I've seen, um, that not benefit, um, families."

There was a sense that "*you need more time to do a good [pre-birth] assessment*", as Jake explained, yet the reality of practice meant that families might be allocated during the later stages of pregnancy and the work feels rushed. Mason et al. (2022a) found similar issues with rigid adherence to LA timescales leaving little time for intervention, especially when it came to accessing specialist services. Metteri and Hotari (2011, cited in Mänttäri-van der Kuip, 2016) highlighted the problem of a pervasive discourse of haste and not having the time to fully understand and meet the needs of the people we work with, as a factor contributing to moral distress. For some, most strongly for Finlay, this appeared to be something that they struggled with and felt needed addressing in practice.

6.4. Swimming against the tide: the influence of the system

Within this section participants reflected on how they felt that pre-birth practice was influenced by the wider context and how factors such as funding and service provision were ultimately shaping practice and, in many ways, letting families down. Some of the discussion within this section allude to the wider concerns regarding child protection processes discussed in Chapter 2, with a focus on risk and investigation over relationships and support. This section focuses mainly on the families where removal after birth was recommended as this was where participants felt most strongly that the system was working against good practice and having every opportunity to get the outcome 'right'. Participants spoke of cycles of trauma and parents having multiple babies removed with limited intervention or support between removals. Some

participants questioned the use of funding for care proceedings and whether there was another way to practice, if there was an opportunity to think differently and more creatively.

Some participants spoke at length about the lack of services available to families following removal. When talking about specific assessments, most of the time they recognised that removal was the 'right' thing for the baby, but they felt that they were unable to enact the 'right' thing for the family members. They discussed how parents often fell in the gaps between children and adults' services, receiving little or no ongoing professional support. This is an area of research that has gained increasing focus in research in recent years, especially within the 'Born Into Care' series being led by Broadhurst and colleagues (Alrouh et al., 2019; Alrouh et al., 2020; Broadhurst et al, 2017; Broadhurst et al., 2018; Griffiths et al., 2020; Mason et al., 2019; Mason and Broadhurst, 2020; Mason et al., 2022a; 2022b; Pattison et al., 2021) and has been highlighted as a gap in practice. In the wider context of child protection, this is also reflective of critiques of the current child protection system explored in Chapter 2, with the focus on the unborn child's needs at the exclusion of parental needs.

Many of the participants within the study were acutely aware of the impact of families not receiving adequate levels of support post-removal and felt strongly that this was something that needed to change. The first findings chapter explored the complexities around who should be seen as the primary 'client' during pre-birth work however, most participants actively discussed concerns about the ongoing needs for the family, regardless of how they managed their focus during the assessment. Annie was someone who maintained a focus

on the baby throughout the assessment, yet spoke of her concerns about a young woman who she worked with where the court had recommended work be undertaken with her after the removal of her first infant:

> *"And it had been a recommendation in the first proceedings that the local authority supported this mum, develop her skills because the chances of her having more children as incredibly high. Erm, and of course that happened [she had another child]. And of course nothing had been offered… And that was a massive gap in services because once they didn't have children, they weren't the responsibility of children's service… And so, you just got into that repetitive kind of, erm, pattern"*

Jake also talked of the cycle of families receiving little support and then returning at a later point with the same concerns, with no further intervention. He said:

> *"They're like, well child's removed, come along to contact. Um, you know, actually that's, that's the time that you need to be pouring the services in not taking services away. Um, if you want to make sure that in a year to two years' time, you're not, you know, starting another assessment and potentially looking at removal because nothing's changed. Um, but if you haven't given parents the opportunity to change, how can we be surprised when they don't. Are parents going to be ones that seek out support when they're still really raw from having a child removed and placed for adoption. Probably not."*

The standout points from these quotes are, "*Once they didn't have children, they weren't the responsibility of children's services"* and *"If you haven't given parents the opportunity to change, how can we be surprised when they don't".* Whilst there is a professional responsibility to continue to engage with parents during care proceedings, once the decision has been made that a child requires permanent placement in out-of-home care or with adoptive parents, parents can find it difficult to access support for themselves and they, "typically disappear from the gaze of services" (Broadhurst and Mason, 2017, p.43). Similarly, once there are serious concerns about the welfare of a child the social work support often moves away from support for parents, to an exclusive focus on the welfare of the child (Smeeton and Boxall, 2011). The literature review outlined the literature on parents' experiences of removal with devastation, grief and loss, emptiness and despair, isolation, and loss of services and benefits (Broadhurst and Mason, 2020a; Marsh, 2016). All of which can lead to an increasing likelihood of the risks that led to the involvement, such as poor mental health or substance misuse, being amplified (Broadhurst et al., 2020a). As Jake highlights, it is therefore unsurprising that parents may not be in the strongest position to actively seek out support following an infant removal. Whilst recommendations may be made regarding parents' needs within court reports, there is no statutory framework which requires the courts or children's services to ensure that these needs are met (Broadhurst and Mason, 2017) and parents are being left without adequate support to work through their issues and ensure they do not find themselves in the same position in the future.

The growing awareness around parents' vulnerability to repeat court proceedings has led to a number of schemes being developed, both in the UK and also the USA and Australia (Broadhurst and Mason, 2019; Grant et al., 2014; Hinton, 2018). Whilst there is evidence that focused and tailored support can improve the lives of parents who have had infants removed and increase their chances of being able to care for a child in the future (Boddy and Wheeler, 2020a; Cox et al., 2017, McCracken et al., 2017; Roberts et al., 2018), this support is still not universally available (MacAlister, 2022). In their review of case law, Ryan and Cook (2019) found many judgements expressed concern, and at times frustration, that not enough support had been offered to parents to come to terms with their past experiences, or to support them to achieve and evidence change. The literature review found that this continues to be a gap in services for pre-birth assessment in particular but Chapter 2 also highlighted how this is a wider concern of the child protection system more broadly. The current child protection paradigm is child centric and focused on child rescue, leaving little space for compassion and understanding towards parents (Featherstone et al., 2014). This was something that some participants were acutely aware of, and which worried them greatly as they were unable to see how to best support families in the current system.

The participants in this study reflected that this gap may be down to funding but questioned the logic of this. These questions have been raised in the wider literature with Broadhurst et al. (2013) arguing that the cost of repeat removals is high and "providing a *reactive* rather than rehabilitative service is not a 'cheap option'" (p.299, emphasis as in original). Some of the participants questioned why it felt easier to go through care proceedings than provide

support to families which could make a difference to the outcome of the assessment. Although they did not attribute this to social policy and political ideology, those that raised the issue struggled with the ethics of it. Finlay spoke about a young woman he had worked with during pregnancy who he described as "*living on crisps and pop*" and not having enough money to top up her key card to heat her home. He felt angry about the fact that money could be spent on care proceedings and yet when he asked for money to top up her gas, he likened the experience to the famous scene from Charles Dicken's (1839) novel Oliver Twist:

> *"I really struggled with that… 'I need to tenner for the gas', 'Well, we're over budget'…. So it was very, um, um, you almost sort of had to go with your tail between your legs to ask for a bit of money… Literally like, please sir please can I have, you know"*

Other participants made similar observations. Daniel questioned why we can use so much funding to go to court, yet could not offer smaller amounts of money that might made a difference to the whole family's life so easily:

> *"Why can we use what I call the armoury of the state so easily on getting it to court, but then it's 'oh, dad needs a bus pass to get to his job interview or, or mam needs another bunk bed', 'Well you gotta go to this panel write that, write this.'"*

Many of the participants discussed concerns about the reactive use of public money and wondered whether it could be spent differently; to provide early intervention which would stop some families experiencing cycles of removal which they recognised were damaging for all involved. As explored in Chapter

2, this discussion has been ongoing within the wider literature of child and family' social work. Whilst there has been an increasing focus on Early Intervention, this has been interpreted differently by different governments (Mason and Bywaters, 2016). Featherstone et al. (2014) argue that the English government have taken an especially punitive and individualised approach to early intervention, which focuses on removing children from their families at an early point to avoid harm to the child or children, rather than supporting families to remain together. Mason and Bywaters (2016) argue that the rising number of children entering LA care is evidence that investment is focused on 'reactive' spending, centred around investigation and child removal, rather than 'preventative' spending which would focus on family support, which is in line with the neoliberal agenda. This use of funding played on many of the participants' minds and they felt that investing more in supportive early intervention would be a worthwhile endeavour. Jake stated that whilst this investment would not stop the need for all babies to be removed from their parents, that if it makes even a small difference then it would be worthwhile. He concluded:

> *"We can't just have this sort of, um, production line of children that just get routinely accommodated year after year. It's not good for them. It's not good for mum, it's not good for dad. Um, we need to think of ways that we, we intervene at an earlier stage and to deal with that."*

Finlay spoke about many examples where he felt families could have been supported earlier in their lives to prevent the cycles of trauma and abuse that led to pre-birth assessments. In one example he spoke about working with a mother who had experience of five newborn babies removed from her care

and questioned how this public funding could have been spent more effectively:

> *"I'm just pulling this out in my head, but you know, why didn't we spend £20,000 when she was a teenager and put her through some really integrative holistic [therapeutic intervention], you know, and you wouldn't have spent half a million."*

Many of the other participants made similar observations mentioning cycles of trauma that continue when families do not receive the right support at the right time. Systemic factors, specifically a lack of resources, have been shown to be a source of moral distress for social workers (Mänttäri-van der Kuip, 2016; Stahlschmidt et al., 2022) and some of the participants in this study reported feeling disillusioned with not only pre-birth practice, but child protection practice more broadly. The interviews often strayed into the wider context of child and family and at times it was difficult to differentiate between pre-birth practice specifically and participants' practice in general. What is key is that when participants were given the time and space to reflect on the 'bigger picture' they were all aware of issues that filtered down into pre-birth practice and affected their ability to implement the support and intervention they felt would be beneficial to families.

6.5. Chapter summary and analysis

This findings chapter has explored how participants attempted to navigate their work to achieve what they felt was the right outcome for both the unborn babies and their families. Much of this chapter has described a power struggle, with participants reflecting that they cannot always enact the outcomes that

they feel are right. Whilst they described setting out with the best intentions, sometimes participants appeared powerless when confronted with more senior colleagues who had a view on what the outcome of their assessment should be, and they found themselves working against cultures of defensive or risk averse practice. More broadly, participants described the powerlessness of working within the current child protection system, which they felt was letting families down; working in a reactive way that failed to recognise the long-term impact of decisions for families. Some aspects of the first findings chapter discussed how the social workers were torn between a focus on the baby and the parents. Here further conflict is discussed with the social workers also being stuck between the organisation/system and the families.

On an individual level, participants all appeared very passionate about the rights of the family and the child. Based on the responsibility and pressure explored in the first findings chapter (Chapter 5) they discussed how they wanted to complete assessments and work with families using a relational approach based on honesty, openness, and transparency. These relationships took time to develop, especially when parents have had previous involvement with children's social care, or where older children had been removed from their care. Despite this, participants spoke enthusiastically about trying to develop strong working relationships that they felt would help families to navigate the challenges ahead, whatever these may be. Core to this was holding onto hope and optimism that things can change for families, either over time, or with the right support. Participants spoke of how this was at the heart of what social work is about. Trying to assess and establish what

would be ‘right; for this baby was challenging, given the consequences of any decision. Undertaking thorough assessments which understood the situation as fully as possible, in light of the information that is absent from a pre-birth assessment explored in the previous chapter (Chapter 5), and developing strong working relationships as a basis for support moving forward, was what was necessary to ensure this was the most robust decision.

Individually, all social workers in this study appeared to be coming from a social justice standpoint. They wanted to advocate for the unborn babies and their families and take measured risks to do things the ‘right’ way. This was in contrast to the risk averse and “risk-to-self averse” (Munro, 2019, p.125) practice that wider concerns have been raised about in both child and family social work more broadly (see Chapter 2), and in previous research on pre-birth practice (see Chapter 3). Their empathy with families, and pain and conflict over the prospect of separating babies and parents was evident throughout the interviews and the emotions around this are explored further in the next and final findings chapter (Chapter 7). Beyond individual practice, this social justice view appeared to waver suggesting that there are cultural and systemic issues which can leave social workers unable to practice in ways that align with their values and can stop them from enacting outcomes that they believe are ‘right’. Participants who were still practicing in teams involved in pre-birth assessments were less likely to be critical of the organisational and systemic barriers to practice than those who had moved on to different roles or left the profession. As with my own reflections, the time and space away from ‘doing’ the work and seeing things in hindsight may have had an impact on how people who were no longer involved in pre-birth work viewed this area

of practice. Alternatively, it may have been a conscious or unconscious coping mechanism for those still working in roles where they were involved in pre-birth work, who continued to experience managerial and bureaucratic barriers to practice. Whatever the reasons, the conflict between what the social workers in this study wanted to do, and what they were able to do had a profound impact on some of their career trajectories and led to them experiencing moral distress.

In participants' responses, there seemed to be an underlying view that organisations did not see pre-birth in the same way as the individual social workers did. There appeared to be limited recognition of the gravity of the work and the level of responsibility associated with making the 'right' decisions for *this* child and their family. Cultural barriers also appeared to undermine the individual social workers' desire to implement a relational approach to their practice, both in terms of time and their control over the outcome of their assessments. The distance between managers or more senior professionals and the families served to separate the decision making from the emotions associated with them. The dissonance between management decision making and personal engagement with families had been extensively explored within social work literature (Smith, 2011), with a view that this erodes the experience of moral responsibility and leads to families' needs being framed in a more abstract and technocratic way (Smith, 2011). For pre-birth practice, the findings of this study raise concerns about the setting aside of emotion and morality within the decision-making as this can have significant consequences for the social workers involved and the families they worked with. This is an area which will be explored further within the final findings chapter.

The missing elements of the assessment discussed in the first findings chapter left more space for complex and risky histories to take centre stage in decision making. Whilst, individually, participants talked about trying to 'balance' this information with the current picture and see things with fresh eyes, the emotive nature of past involvement appeared to significantly drive some decisions towards separating an infant from their parents shortly after birth. Annie and Bonnie's very candid and emotive recollections of their decisions being overruled in practice, before their recommended outcomes were ultimately enacted, raise serious questions about the risk aversion of these decisions. Whilst prior research has identified the risk aversion in pre-birth decision making as being an individual factor (Critchley 2018b, 2020a; Hart, 2001), this study situates it beyond, or even at odds, with the individual social workers. In these instances, the participants described their work feeling futile and that they were powerless to pursue what they felt was right, suggesting the impact of managerialism on individual practice. Some participants in the study alluded to the fact that they were caught between a family and their organisation, cast as agents of the state enacting things they disagreed with.

Starting this research, I had not anticipated that any other social workers would have faced anything that was remotely like my own experience in my work with Amanda and the loss of control I felt about the outcome for her and her baby. Two of the ten participants having such comparable experiences of having their decisions overturned and being made to pursue a course of action they disagreed with was a startling and unexpected finding. Whilst this is a small-scale study and generalisations are not possible, the experiences of Annie and Bonnie, along with my own experience, raise questions about the erosion of

professional discretion and decision making in pre-birth practice. This has implications for both the social workers undertaking the work and the children and families they work with.

How time was used within the culture of the organisation also had an impact, with formal meetings and processes guiding the work, rather than the relationships participants felt were key. Time during pregnancy was described as a window of opportunity but this appeared to be balanced with a pervasive discourse of haste (Metteri and Hotari, 2011, cited in Mänttäri-van der Kuip, 2016). Again, this is something that has been explored within the wider social work literature (Pascoe et al., 2022). Within an increasingly bureaucratic system influenced by decades of neoliberal ideology, the conflict between time spent with families and time completing paperwork has been shown to lead to heightened stress and dissatisfaction with the role (Yuill and Mueller-Hirth, 2019). Questions have also been raised about how this benefits children and families, with a concern that a focus on procedure can lead to losing sight of the needs of families (Fenton and Kelly. 2017; Pascoe et al., 2022; Weinberg, 2016). For pre-birth assessment work, where the timeframe for effective assessment and support is limited, this raises ethical questions about how time is being used in practice.

At a systemic level, there was a sense of frustration and sometimes anger at the broader issues of funding and resources. Previous studies have shown that many social workers experience a disconnect between the demands of austerity and their personal and professional values (Grootegoed and Smith, 2018). In these discussions, the participants thinking remained aligned with the families; they wanted to be able to do something different so that families

could get the support they needed. Some of the participants had experience of repeated assessments for the same family and could see how there was unlikely to be change in the current system, where parents 'fell down the gaps' between services after their newborn baby was removed. They recognised that this ultimately had a negative impact on the families and some participants experienced moral distress over their inability to enact the support they felt was required for these families.

Some participants spoke about mother and baby placements and a desire to be able to fully assess parenting capacity once the baby was born, but there were limited examples where this had been the case. There seemed to be an acceptance by most participants that these decisions could be made before birth, even with the missing information. Despite this acceptance, there was a discomfort with this, but no participants raised the question of whether newborn infants should be routinely separated from their parents. This study was undertaken in the North East of England, where residential assessment or parent and baby foster placements are not routinely available as a result of budget restrictions, despite this not being the case nationwide (Mason and Broadhurst, 2020). The findings of this thesis so far have highlighted the gravity and severity of pre-birth practice, where decisions are made before birth in lieu of several elements of assessment. In London LAs, pre-birth assessment work appears to more often continue after birth, with assessment centre or parent and baby foster placements being "routinely offered before separation was considered… so that evidence of parenting capacity could be fairly assessed after birth" (Mason and Broadhurst, 2020, p.10). Chapter 2 explored the impact of austerity on child and family social work, and the

specific impact of this within the North East of England. These differences in routine practice raise significant ethical and moral concerns regarding the impact of austerity and funding on decisions for individual families. Of all of the participants, only one had experience of practice outside of the North East and Yorkshire. It is therefore unsurprising that participants were not aware that there are different expectations of pre-birth assessment outcomes across England.

The next and final findings chapter will build on some of the emotions around the work, exploring how participants were supported with pre-birth work, considering both practical supports to prepare them for the work, and emotional support to help them process the work.

7. Findings Chapter 3: “Wildly underprepared and really scared”: Practical and emotional support with pre-birth work

7.1. Introduction

This chapter explores how supported the participants felt to undertake pre-birth assessments, and in turn how prepared they felt for the work. The central theme of this chapter is support for social workers, whether this is practical or emotional. This final findings chapter builds on the previous two, recognising the complexity of the work and the challenges to getting the work ‘right’, considering how equipped the participants felt in taking on pre-birth work. This is the first study that has explored how supported social workers feel when undertaking pre-birth assessments and considers how they were supported to prepare for the work, and how support during and after the work impacted on them. To varying degrees, all the participants spoke of feeling unprepared for the work, with a sense that they learned how to do pre-birth assessments as they did them and hoped that they were doing them right. This calls into question how social workers can be better supported to be more prepared ahead of the work and raises moral and ethical issues about the impact of the lack of preparation and support regarding pre-birth. During pre-birth work, all participants recognised that assessments with unborn babies and their families can be highly emotive. They discussed how this requires strong and trusting emotional support systems to be in place to help social workers manage this, in order to mitigate any negative impact it could have on their wellbeing and for them to be able to undertake the work. Participants in this study had mixed experiences of support in practice, and the implications of this are explored within the second part of this findings chapter.

This chapter is separated into two sections ‘Families as a training ground: learning how to work with families before birth’ which focuses on the support social workers need to practically prepare for the work, and ‘”Emotionally it’s hard”: the need for emotional support’, which explores good practice and areas which could be developed in terms of the support participants received.

7.2. Families as a training ground: learning how to work with families before birth

All of the participants in this study discussed how they did not feel fully prepared to undertake pre-birth work and felt that this was an area where support, education and training needs to be improved. The previous chapters have explored some of the challenges of pre-birth social work practice that make the work distinct from practice with older children. Whilst it is impossible to be prepared for every eventuality within social work (Béres, 2019), which by its nature is complex and challenging (Jansen, 2018), participants raised questions about whether more could be done to prepare them prior to undertaking any pre-birth work with families. There was a sense that this work feels ‘different’ which posed some practical and at times, ethical tensions around how best to undertake the work. Many of the discussions were based on ideas explored within the first findings chapter (Chapter 5) which outlined the unique challenges of pre-birth assessment, and the pressure and responsibility associated with the work.

Whilst the first findings chapter discussed how the participants did not see pre-birth work as more inherently complex, this chapter will discuss their recognition that it was different to other aspects of child and family social work. Many made comments similar to this point from Isabelle, who reflected that

pre-birth work "*almost felt different*" to other areas of child and family practice. This has had an impact on how participants felt about completing the work with many participants talking about feeling less confident, anxious or even fearful of taking on the responsibility of pre-birth assessments, especially for the first time. Ella explained, *"I think when I first start-started doing them, I didn't really know what I was doing because they are quite different compared to other types of assessments."* Even participants who were highly experienced were able to recognise in retrospect that they could have been better prepared for the work, Gabby had been qualified for over a decade and explained, "*I don't think I was as prepared as I would have wanted to have been or what now I can see with experience*." As has been outlined in previous chapters, participants were acutely aware of the potential impact of their assessment and the consequences of getting this wrong, but this was juxtaposed by the fact that they, "*muddled through"* the work, as Finlay put it.

This sense of feeling unprepared, or unconfident had both practical and emotional ramifications for participants. Chloe said that she felt *"totally deskilled"* and "*wildly under-prepared and really scared"* after being allocated her first pre-birth assessment to complete. This feeling of unpreparedness was expressed by many of the participants but Chloe expressed this very clearly when she expanded:

> *"Most of the time I feel like I kind of find my feet and I know where the goalposts are kind of naturally I can like work that out. But with this pre-birth assessment, the first time I was like (pause), I, I was just like err what? It was like doing my first ever assessment again. I was like, I don't e-. I don't know what I'm looking for. I don't know what, what is a*

> *good thing? What is a bad thing? I don't know what I'm supposed to write. I don't know what supposed to find. I don't know how I'm supposed to find that information. I don't know what's useful information and what's not. And just don't I was just like, I literally, I don't even know what I don't know."*

One of the key reasons for this feeling of unpreparedness was the lack of guidance, training and research available to participants. This is in keeping with the findings from the literature review that guidance and training for pre-birth practice are currently lacking (Broadhurst et al., 2018; Critchley, 2018b; Lushey et al., 2017; Mason, Robertson and Broadhurst, 2019; Mc Elhinney et al., 2019). All participants discussed that they felt this was an area that could be developed further for pre-birth practice. Many of the participants had undertaken pre-qualifying education or post-qualifying training around newborn babies and families, but there had been no content on assessing unborn babies and working with families during pregnancy. Participants felt that LA guidance that was available was more about processes than how to do a pre-birth assessment well, or how to approach the task. As Ella reflected, *"I found that there wasn't really a lot of guidance on how to do them",* she later explained that what was available was, *"quite procedurally based",* focussing on timescales as opposed to practice or the content of assessments. Some participants suggested training or research resources on practical aspects of the assessment would have been useful, as Jake explained:

> *"I think it would benefit from... some in-depth training and, and you know, really just unpicking the difference between you sort of single assessment of what you need to achieve from that and, and, um, what*

you need to, what, what you need to focus upon within a pre-birth that's going to be very different from your single assessment."

Some participants also raised that further training was needed around the impact of different risk factors during pregnancy and shortly after birth. Gabby had done some reading herself due to her interest in aspects of pre-birth, she reported:

"I think they need to understand the differences between pre-births and normal [assessments] in terms of… I suppose the sort of biggest risk factors, so why domestic abuse is different in terms of the risks that could increase. Um, issues around sort of the impact of drug and alcohol use… I think they need to understand what it's like in terms of, you know, being a stressful time in itself anyway and kind of acknowledging that and just be mindful of that when they're doing the assessment."

As with Hodson's (2011) findings, none of the participants in this study used any guiding theoretical perspectives or literature to base their work on, as they had been unable to identify any literature to support them. Consistent with Lushey et al.'s (2017) study, none of the participants cited using the pre-birth assessment tools developed by Calder (2000, 2003, 2013) or Corner (1997) and none of the participants were aware that such tools existed. The limited availability of guidance, research and resources around pre-birth assessment led to participants primarily learning how to do pre-birth work through reading colleagues' previous pre-birth assessments, and through the experience of completing them themselves.

Almost all participants discussed reading examples of colleagues' previous assessments as a way for preparing for their own pre-birth work. This appeared to be the primary way that the participants were 'prepared' for undertaking pre-birth assessments in practice. Bonnie explained, *"Somebody showed me one of their previous assessments, so I know what I'm supposed to be doing"* with almost all participants reporting similar experiences, which supports Lushey et al.'s (2018) findings. Informal learning from colleagues can be highly beneficial in terms of developing practice (Boud and Middleton, 2003) and is cited as the most frequent form of workplace learning (Kyndt et al., 2014). Whilst it can be useful, there are concerns that it can be framed by context and culture, with a view that 'that is the way things are done around here' (Bernstein, 1999). The second findings chapter (Chapter 6) discussed concerns about culture within teams and the impact this can have on decision making and outcomes. This raises questions about how social workers might be able to challenge views of other professionals, or recognise that challenge may be necessary when their understanding of the work is only shaped by the knowledge and practice within their teams. Trevithick (2012) argues that knowledge for social work needs to be balanced between factual knowledge from research, theoretical knowledge, and practice knowledge developed through experience. This raises some concerns about the way that people are 'learning' pre-birth practice as there is an absence of factual and theoretical knowledge being used, and the practice knowledge of colleagues is being relied upon when it is unclear if this is 'good' practice. There is also variation across the country in terms of what is expected within pre-birth assessments (Lushey et al., 2018) and the quality of the assessments (Hodson, 2011; Ward

et al., 2010). This variation raises concerns about social workers not drawing on a wider evidence base than their own experience and the experience of their colleagues to structure their assessments and make decisions, which has the potential to compound any elements of poor practice.

In addition to learning from reading other assessments, many participants also reported learning through their first experiences of pre-birth assessments. This meant that the participants often talked about feeling more confident and prepared as their level of experience grew. As Annie explained:

> *"You literally just got it and you did it. But then you sort of find your own way of working. Erm. I remember the first one I went to that went to court. Learning so much from that process that you then implement in your next one. You know, so it was like the more you did the more you sort of learned."*

As with informal learning, experiential learning is also an important aspect of skill acquisition and professional competence (Cheetham and Chivers, 2001; Trevithick; 2012) and is a cornerstone of practice education within social work (Bogo, 2015). However, the experience alone is not sufficient to support learning and development of skill, reflection and support are required for effective experiential learning (Beaty, 2003). As the next section of this chapter will explore, the experiences of support and space for reflection differed greatly across the participants leading to different experiences in terms of preparedness for pre-birth work.

For some of the participants, this process of learning through experience led to them reflecting that their first assessments may not have been very good.

That is not to say that the outcome would have necessarily been different, just that they could have executed it better with more opportunities to prepare. Chloe reflected on her first pre-birth assessment, explaining, *"I think that initial assessment was a really bad one. If I was going back to write it now I know I would write it very differently… Because I didn't know what I was looking for."* Jake discussed similar reflections of his first pre-birth assessment, *"'Here you are you newly qualified social worker, here's a pre-birth assessment to go and do', um, so I can't imagine my first pre-birth assessment was very good (laughs). Looking back at it."* He felt that pre-birth assessments were sometimes given as "*learning opportunities"* but felt that the stakes were too high for everyone involved to consider them this way and that they should only be undertaken *"by some of your most experienced practitioners".*

Almost all participants discussed undertaking pre-birth assessments early within their social work careers, either as students or NQSWs. Their reflections across the findings of this study around the complexity, challenges and gravity of pre-birth work raise questions about how appropriate this is without effective guidance and support being in place. Some participants believed that pre-birth assessment was too significant a responsibility to be undertaken by people without specialist training, and others believed they should only be completed by specialist teams. Finlay explained, *"I think they should have like dedicated specialists teams [for pre-birth work]. I don't think, I don't think it should go through the front door service and then we pass it to a longer-term worker."* Finlay believed this would be more effective as it would provide consistency for families, and also ensure that any social workers undertaking pre-birth assessment had access to more specialist resources. This is in line with

Mason and Broadhurst's (2020) study, where most participants felt that pre-birth practice required specialist skills and knowledge. From the participants experiences and discussions, this access to specialist skills and knowledge appears to be lacking in the North East. Following the completion of the data collection for this study, Mason et al. (2022b) have published their draft best practice guidelines for when the state intervenes at birth, which also discusses the pre-birth assessment period. These offer some guidance on pre-birth practice, drawing on good practice examples from across the country. The guidelines were trialled between January and August 2022 and final guidelines will be available late 2022. This may offer a basis for guidance for LAs and individual social workers to develop training and resources. Despite this, Mason et al. (2022b) recognise that there are, "numerous challenges that make it difficult to achieve good practice in some local authorities" (p.1), many of which were raised by the participants from this study and discussed in the second findings chapter (Chapter 6), and change would be required at an organisational level to be able to implement some of the recommendations.

Two participants had the opportunity to co-work their first pre-birth assessments with more experienced social workers. They found this to be a supportive process in terms of managing the complexities of pre-birth assessments and how it helped them to develop their own practice. Isabelle had undertaken a student placement in a specialist pre-birth assessment team and yet still found co-working pre-birth assessments with a senior practitioner as an NQSW to be a helpful and supportive process. Harry had also been supported closely by a senior practitioner through the process*, "it was being guided I suppose as well 'cause you're not just left alone".* He discussed how

he found this helpful in terms of discussing his thoughts and feelings and being able to use this process to question and change the recommendation of a pre-birth assessment that had been transferred to him, where the initial plan was to apply for a Care Order once the baby was born. Co-working as a way of learning is a highly valued way to develop skills within social work (Wilson and Flanagan, 2021) however most participants talked about doing their first assessments without the support of another social worker. Co-working may offer an opportunity to address some of the concerns about social workers feeling unprepared for this area of practice.

7.3. "Emotionally it's hard": the need for emotional support

The second findings chapter raised concerns around social workers experiencing moral distress when they were unable to enact the decisions they felt were 'right', however there were further emotional challenges that the participants discussed. This section will further explore some of these, and the impact that both formal and informal support had on mitigating them. Participants had a broad range of experiences in terms of how supported they felt. Their perceived level of support impacted on the way they felt about the work, and all participants discussed the importance of good support networks and supervision when undertaking pre-birth assessments.

One thing almost all participants agreed upon was that pre-birth work can be highly emotive and requires additional levels of support, which reflected in the limited literature currently available (see Everitt et al., 2015; Hodson, 2011; Marsh et al., 2019; Mason et al., 2022a; Powell et al., 2020). Whilst the way that they talked about assessments differed, it was clear that pre-birth practice had the potential to be emotionally challenging and the support participants

received had an impact on how this was experienced and how well they were able to manage this. The emotionality of pre-birth practice for social workers, rather than focusing on removal, is something which is currently absent from the literature. Only a very small part of Critchley's (2018b; 2020a) work identifies wider emotional implications of pre-birth work for social workers. The emotional impact of infant removal on social workers has also received limited attention in the literature (Marsh et al, 2019; Mason et al., 2019), with only Marsh et al.'s. (2019) study exploring this. This mirrors children and family social work on a whole, where the expression and management of emotion is an under-researched and under-theorised concept (Winter et al., 2019).

The emotional aspects of the work were very clear within the findings and participants all discussed the emotional labour of the work. Some participants talked about specific aspects of the work being more emotive, others talked about the experience of being involved in pre-birth assessments as emotive by nature. There was a sense that pre-birth assessment could be *"really emotive"* as Isabelle put it. Ella explained:

> *"I think emotionally it's hard and it's upsetting and I, and I think part of me just feels like, well, what chance has a child got if we're involved in his life before it's even born. And I, as me, that's quite like that's upsetting. It's sad."*

Participants all recognised the possibility of being involved in infant removal as highly emotive and challenging. This is not surprising, given that separating a child from a parent is one of the most emotive aspects of practice (Mills, 2011; Miranda and Godwin, 2018), which was explored within the first findings

chapter (Chapter 5). Participants discuss how the work could *“take its toll”* over time, as Harry put it. There was recognition that there needed to be support systems in place to help social workers manage these emotions, as they were unavoidable. Finlay explained:

> *“It did have an impact… I think if you're not given the right forum or place to explore and discuss and reflect on them, I think it sort of numbs you a bit makes it harder because there's so much like vicarious trauma and you just sort of put it down and put a down and push it down and push it down.”*

The level of emotional support that they received ultimately made the difference to their confidence and ability to manage the work. Considering the participants of this study holistically, those who felt more supported ultimately described feeling more confident in their decisions and felt less conflicted. Or felt that any conflict was able to be resolved in time. Whereas those who felt less supported questioned their role and ability to manage the work. For some, this was a contributing factor to them leaving their roles. Even those who had felt supported themselves raised concerns about people having less support, especially within the realms of home or hybrid working, which has increased in social work following the Covid-19 pandemic (Cook et al., 2020).

Whilst Jake’s own experience had felt supportive in many ways, he raised concerns about the current balance of experience in the team within his LA due to high turnover of staff and the impact of this. He discussed how he had felt supported when he first started in social work and was undertaking assessments; that there was a “*reasonably well-balanced team*” in terms of

levels of experience, and there was always someone there to "*bounce ideas off*". He was concerned about NQSWs starting within teams now where he felt there were less experienced social workers to draw from and the added complication of agile working worried him. He felt this removed the support networks from social workers, *"You become more removed from your, your sort of safety nets that, that exist to sort of talk to and sound out issues"* and wondered how this would impact both the social workers and the quality of their work in this environment. Isabelle also had positive experience of support herself but raised worries about social workers in less supportive or more disjointed teams:

> *"I would say I would worry about social workers undertaking such assessments when they're in a team that feels disjointed or they're not feeling generally supported. Um, because then there is gaps in that reflection and identifying when others are maybe feeling emotional or it's been difficult."*

Almost all participants agreed there was a need for reflective supervision and support when undertaking pre-birth assessments, beyond case management supervision. Supervision is an integral part of social work (Davys and Beddoe, 2020; Munro, 2010) and key for high quality social work practice (Beddoe et al., 2015; Wilkins, Forrester and Grant, 2017). Good supervision requires a balance of education, administration and support (Kadushin and Harkness, 2002). Despite this, there have been ongoing concerns that supervision is focused more on managerial administration and practice surveillance rather than reflection and support (Rankine and Thompson, 2021; Wilkins et al., 2017), which has been linked to the impact of neoliberalism on social work

(Spolander et al., 2014). This has been highlighted as a potential issue for some participants, discussed later in this section. For pre-birth practice in particular, many of the participants felt that there should be additional support offered which focuses on the impact of the work on the social worker and was more reflective in nature. Annie felt that this might mitigate some of the negative effects that dealing with such complex and emotional work can have: *"I always felt pre-births and care proceedings should have additional supervision that looked at the impact on the social worker during the process. As well as the standard case management supervision. Afterwards is too late"*

Bonnie, who had openly discussed struggling with some aspects of her work, felt that it was important that this support was offered by people who understood the context of pre-birth practice. She had accessed counselling services through occupational health after experiencing strong emotions about one pre-birth assessment, but felt that was not the correct source of support. She explained:

> *"[Social workers are] not gonna stay unless they're supported emotionally. Because it only takes one. It only takes one case doesn't it? … And there is no, there is no capacity and there's no framework for it unless you decide just to get counselling through work. And that's not necessarily what you need. You need somebody who can understand the psychological impact."*

These arguments are applicable to all complex and emotive work that child and families' social workers undertake however the findings of this thesis position pre-birth assessment work as a highly complex, ethically and morally

fraught, and emotive area of practice which means this support is crucial. The decisions being made about unborn babies carry a high level of responsibility, uncertainty and participants in this study talked about not fully understanding how to make these decisions, or what to look for, due to a lack of guidance and training on pre-birth practice. Therefore, reflective and in-depth supervision may help to support social workers with some of these issues.

For this to be possible, there would need to be trust between social workers and their supervisors, and many participants discussed the importance of this. Trust was necessary so they could speak openly about their thoughts, feelings or worries without fear of judgement. This support could come from their colleagues or their supervisors, but ultimately if they did not feel they could trust their supervisors or managers, or did not feel that they were trusted, this could have a negative impact on them. Bonnie explained how she would feel different in her current role to the role she had left previously:

> *"I didn't feel trusted. I didn't feel that my view, my view wasn't trusted. … You know [now] I would be listened to. And I think I'd be able to negotiate it better. And then I wouldn't have that same emotional response… The emotional response was seen as weakness"*

This relates back to the cultural factors discussed within the last chapter (see section 6.3) and whether the participants were working within an organisation where they were able to challenge practice and have ownership of their own assessment outcomes. Some participants discussed the strength of support within their teams in being able to draw on, and sometimes fall back on, their more experienced colleagues and managers, which could be a concern for

those working in isolation from their teams through hybrid working, as mentioned previously.

Many participants discussed the role of their team as an informal support system, which helped them deal with the emotional nature of the work. As Ella explained:

> *"[To] be able to discuss it, um any difficult visits or anything like that with colleagues and a manager afterwards. Um just getting that reassurance that what I'm doing is the right thing. Because as I've said, it's a hard… Cause I think the thing that's difficult with a pre-birth assessment is that it's emotionally hard. So you need that emotional support. Um, more than it being like logistically difficult, … but it's not as hard as the emotional side"*

Social work teams can provide a secure base for social workers (Cook et al., 2020), supporting them to cope with the emotional demands of the work, as well as offering an opportunity for open learning and development (Biggart et al., 2017). Daniel discussed being able to speak to his managers and co-workers and stated, *"I can't think of a time I haven't been supported"* and discussed the value of having a supportive team around him in his work. Chloe talked about struggling with her first pre-birth and not feeling prepared for the work, as discussed earlier in this chapter. She described how she felt she was able to rely on her manager to support and guide her through the process:

> *"'Cause it was my first time doing it because they knew how worried and all over the place. I was about this case. So my ATM did a lot of the like leg work with me to support me. Cause otherwise I wouldn't*

have, they knew that I wouldn't have done it if it had just been me, I would have given them a really woolly statement that would have been like, well, I don't know if we should remove this baby (laughs)"

Whilst many participants discussed positive aspects of support, some participants did not have a positive experience and discussed feeling unheard and isolated. For some, pre-birth work had been an area of practice that had presented them with significant struggles and left them to question their role. For three participants, their involvement in pre-birth and the lack of support they received was a contributing factor for them leaving their roles. Annie, Bonnie and Finlay discussed how people did not notice when they were struggling and how this ultimately influenced them. Annie reflected on how this felt at the time:

"I knew that things were happening, and that, but, but you know. Managers don't even look for things like that, you know. Everybody else could see that I was struggling with everything, but you just keep going don't you. Erm and I think that's, sort of pretty poor of, of, in a safeguarding team… So you leave either to go and do another job, because that's the right... Or you leave because you're not going to be a social worker anymore."

Annie made the decision to leave social work and allow her registration to lapse, she cited her involvement in complex pre-birth assessments as a *"probably quite negative and significantly influential"* factor in this decision. This was due to the complexity of the work and the cumulative emotional toll that this had taken on her, which she felt may have been mitigated with

appropriate support systems being put in place. Finlay reported a similar experience of feeling unnoticed when he was struggling:

> *"I was sort of becoming very unwell. (Laughs) um I was very stressed. I was sort of overworked, um, running to family court all the time and metaphorically I was just running around with my head on fire and I felt like no one was noticing"*

Finlay had tried to raise concerns about his struggles with pre-birth practice to his supervisor, but felt that these were dismissed:

> *"Anytime I sort of tried to voice some of the, um, anxieties, concerns, feelings that I was having, it was very much, you are the baby social worker. This is about the baby. Yeah. No room for, um, feelings, (laugh) emotions, um, complexities (laugh), you know… You're the baby social worker. And that was the end of it…. it was like, I know it's really difficult, but that's the plan and you're the baby social worker and you're doing it for the right reasons, you know? So it was just sort of like batted aside really."*

He felt that the environment he was working in was "*toxic*" and that his supervisor would often want to skip more difficult conversations about families, which increased the burden on him and the feelings of responsibility. Ultimately, he ended up becoming very unwell and had some time off work, before leaving his post and moving into a different area of child and family social work. This raises concerns about supervision which fails to recognise the complexity and ethical dimensions of pre-birth practice.

Bonnie discussed how she felt support could be tokenistic and supervision was sometimes used to cover managers rather than offer a safe reflective space to explore ideas. She struggled with one pre-birth assessment in particular and when she raised how she was feeling about this in supervision, she felt it was met with irritation:

> *"The last, the last one I remember her saying to me really clearly. 'Oh, I thought you were more experienced at pre- pre-birth assessments and this' I remember her saying that. She was, it was almost like she was irritated that I needed more support, but it was more than that. She'd, she was, she was covering herself. She was covering herself for not supporting me."*

This was in direct contrast with an earlier experience of pre-birth assessment where Bonnie felt supported, which led her to feel more confident and positive about the work. Despite being a student social worker at the time and reporting that, *"I pretty much, got thrown in at the deep end, and started this piece of work… I didn't feel prepared at all",* it was the support around her that made the difference. She reported, "*I guess the initial one as a student actually felt quite positive (pause) because I felt supported".* This experience serves to highlight the impact of good support systems during pre-birth work. Even when people do not feel prepared, the support around them can mitigate for this.

Both Bonnie and Finlay felt blamed for struggling with the work, even after disclosing how difficult they were finding it. When Finlay returned to work after time off due to stress, his manager accused him of, "*[leaving] the team in a mess*" and asked, *"How can you assure me it's not going to happen again?"*.

He was also offered support to prioritise his diary, which he felt was *"offensive"* as the issue was the lack of support and the complexity of his workload, rather than his organisational skills. Even after returning, he reported that he was:

> *"Just heading for a breakdown… It got to the point where I couldn't keep any food down… Like just really unwell. Um, and I thought if all I'm going to get from this authority is do I want help to prioritise my diary? Um, I can't do this."*

Bonnie talked about how her raising concerns about her own wellbeing had been *"Seen as a flaw"*. After she had left her post and moved to another team in the same LA she found out this had been mentioned on her appraisal:

> *"When I first got the job at [TEAM], it was mentioned on my last appraisal that (pause) I didn't even know they'd put it, but it was something about, you know, struggled with resilience, struggled to be resilient. And when my new manager read it, she said, 'oh, that really surprises me about you'"*

She felt it had been seen this way as her manager, "*was quite a strong, strong person… it wouldn't have impacted on her. So [I] don't think she realised it would impact on other people*." For both Bonnie and Finlay this blame had an impact on their career trajectories and how they viewed themselves, making them question whether they were good enough or strong enough to work in child protection. For Bonnie, she reflected, *"That was the one that tipped me over… That was the one that ended my safeguarding career."*

7.4. Chapter summary and analysis

This chapter has highlighted several points which are significant for pre-birth practice. Firstly, it has uncovered how unprepared for pre-birth work social workers are, due to how 'different' the work feels to other areas of assessment and intervention. Overwhelmingly, all participants explained how they did not feel ready for pre-birth practice; with no guidance or training available to help them understand what they were assessing, or how to do this, before completing their first pre-birth assessment. 'Learning' how to do pre-birth assessments came in the form of reading colleagues' assessments and through the experience of doing them, which in hindsight many of the participants reflected must have impacted the quality of their work. Two of the ten participants had an opportunity to co-work their first assessments, but most were left alone outside of formal and informal supervision to "*muddle through*" (Finlay). Considering the level of responsibility associated with the work and potential consequences for the unborn child and their families, this left the participants feeling anxious, fearful, and deskilled. Whilst participants felt strongly that there should be more training and guidance around undertaking pre-birth assessment work, there was a 'taken-for-granted' viewpoint associated with this, that it was just the way things were.

Several points made in this findings chapter relate back to the impact of neoliberalism and managerialism on social work. There was discussion about how the 'guidance' available for practitioners in LAs was procedurally based and focused on timescales and meetings, with a focus on *when* to do the work rather than *how* to do the work. This suggests that the impact of managerialisation on pre-birth work has reduced the role to a set of tasks to

be undertaken, rather than acknowledging the relationships, emotions, uncertainty, and complexity associated with the work. Supervision appeared to be viewed as a way of auditing practice, rather than as a space for reflection, critical thought and professional curiosity. Finlay's emotive account of having his emotions disregarded as he is *"The baby's social worker… doing it for the right reasons"* is suggestive of the child centric child protection paradigm discussed in Chapter 2, leaving little space for discussion beyond the tasks associated with the work for Finlay and participants with similar experiences.

All of the participants spoke of the emotional nature of the work, regardless of how many years they had been practising. The recognition and support that they received in light of this varied considerably, with some participants reporting having constant formal and informal support, to others feeling isolated, alone or even blamed for appearing too emotional. This suggests that recognition of the emotionality of pre-birth work is not universal, yet unquestionably all participants argued that pre-birth work carries high levels of emotion. The consequences of these emotions not being recognised in practice are evident in the experiences of three participants, for whom involvement in pre-birth assessments altered the courses of their careers and had a negative impact on their physical and/or emotional wellbeing.

Many participants discussed undertaking their first pre-birth assessments early within their social work careers, or even as student social workers. Anecdotally, working within social work education, I know that this is not unusual, at least within the North East region. Most participants did not question whether they were qualified or experienced enough to do the work but the findings of this thesis would argue that it is not appropriate for early

career social workers to be undertaking such complex and highly important work due to the consequences for the children and families involved; not least without sufficient preparation and support.

In isolation from the other chapters, this chapter paints a very worrying picture of how social workers are prepared for and supported with pre-birth work. It has raised significant questions about how ill-equipped and inexperienced social workers are undertaking assessments which use families as a training ground for practice, with limited recognition of the ethical and moral consequences of this. This is highly concerning given that the consequences of the decisions for children and families, which have the potential to be devastating and life altering. The impact extends to the social workers too, with involvement in pre-birth social work having had negative consequences on some of the participants in this study. When considered in the context of the other findings chapters, this picture becomes even more alarming. The first findings chapter considered the gravity of the work balanced with uncertainty of pre-birth assessments, with limited recognition of the complexity involved in the work. The second findings chapter considered how social workers attempted to navigate the work to enact the 'right' outcome for the unborn baby and their family, exploring the cultural, organisational and systemic barriers that can impact decision making. Arguably, through the current means of 'preparation' for pre-birth work, social workers early in their career are being indoctrinated to a culture of the 'way things are done around here', with no way of understanding that things could be done differently. For instance in relation to the use of post-birth assessments through residential or parent and baby

foster placements which is more usual in London boroughs, but highly unlikely in the North East of England (Mason and Broadhurst, 2020).

These taken for granted way of working and assumptions around practice cannot be challenged in a forum where the only ways of learning are reading other assessments and basing ways of working from colleagues who have gone through the same experiences. Within the scope of pre-birth assessment, this leaves social workers with limited capacity for critical thought and further compounds issues associated with the impact of neoliberal ideology in social work, such as managerialism and bureaucracy, creating patterns of accepted practice that are unlikely to change. Similarly, if social workers are not being supported, and the conflict and emotionality of the work is not being recognised, this is a further barrier to them raising concerns or asking questions. These factors further compound their loss of control and place them in a vulnerable position. Bonnie's and Finlay's very raw accounts of their own experiences serve as cautionary tales. Both individuals attempted to challenge practice and raise concerns, both about the decisions being made which were explored in the second findings chapter, and their own wellbeing, as explored in this chapter. They felt their concerns fell on deaf ears and ultimately left their roles, feeling powerless to challenge a culture and system that they felt disillusioned with.

8. Summary and Conclusions

8.1. Introduction

This study is the first in depth piece of research to explore the experiences of social workers undertaking pre-birth assessment. Despite pre-birth assessment first being introduced to practice in the 1970s (Fairburn and Tredinnick, 1980) and rising numbers of infants being born into care across the UK and the Western world (Alrouh et al. 2020; Bilson and Bywaters, 2020; Broadhurst et al., 2013; 2014; 2018; Harrison and O'Callaghan 2014, Harrison et al., 2020; Hestbæk et al., 2020; Pearson et al., 2020; Raab et al., 2020) pre-birth assessment has been an area which has received limited academic research (Critchley, 2018b; 2020a; Flaherty, 2021; Hart, 2002; Hodson, 2011; Mason et al., 2019). Whilst research on pre-birth assessment is a growing area, the lived experience of social workers undertaking pre-birth assessments has been almost entirely absent from the literature (Mason et al., 2019). The voice of social workers is often missing from research and policy development (Jones, 2001, Jones et al., 2008) with many arguing that further attention needs to be paid to their lived experiences and voice to develop policy and practice (Ferguson, 2011; Gordon, 2018; Parsloe, 2001). This study offers insight into social workers' experiences and has provided them a platform to share what is like to work with families before birth; undertaking pre-birth assessments, providing support, making decisions and intervening where necessary. The insight from the ten participants has highlighted some significant issues with current pre-birth social work that have wide-reaching implications for social work education, practice and management, and research.

This final chapter will draw together the findings from across the research and bring this thesis to a close. It starts by summarising its main findings and considering how these have addressed the aims and objectives. This is followed by an outline of the original contribution of the study and how it extends current knowledge on pre-birth assessment. This leads onto the implications of these findings for practice, policy and management, education, and research, where several recommendations are made. The limitations of the study and the impact that these have on the quality of the research will be discussed. The dissemination strategy for the findings is then considered before the thesis is concluded, reflecting on my own learning from the study, and the role of this thesis within the Professional Doctorate process.

8.2. Summary of the main findings and how they address the aims and objectives of the study

This thesis sought to explore the experiences of social workers undertaking pre-birth assessments. This was not confined to the assessment task itself, but the associated work, which often extends beyond the birth of the child. The topic for this research initially arose from my own experiences of pre-birth assessment in practice. As I explored in detail within the introduction to this thesis (see section 1.3), pre-birth assessment was an area of child and family social work that I had enjoyed as a practising social worker. Despite this, my experience with one family changed how I felt about it and led me to question the moral and ethical dimensions of making decisions about children before they are born. Upon commencing a Professional Doctorate in 2019, my desire to undertake research on the topic of pre-birth assessment was solidified when an initial exploration of related literature highlighted a distinct lack of research

in this area. Within the available literature, the experiences of social workers were almost entirely absent. My reading also highlighted variations in practice across the country, and concerns that the North East of England has some of the highest rates of infant removal in England (Bilson and Bywaters, 2020; Broadhurst et al., 2018). My own practice was within the North East of England, and I continue to work within social work education within the region, yet I was surprised by this finding. I had been unaware that the rates of infant removal differed so significantly across the country and from my own experience in both practice and social work education, I would not have known some areas of the North East had such comparably high rates of infant removal.

The combination of my own experience, the lack of research on social workers' experiences, and the statistics for statutory intervention shortly after birth in the North East of England led me to focus my research on exploring this gap. Therefore, the aim of this study was to gain an understanding of social workers' experiences of undertaking pre-birth assessment and associated work with families. The objectives were:

- To explore social workers' understanding of pre-birth assessments and how these relate to other aspects of children and families' social work.
- To explore the impact on social workers of undertaking pre-birth assessments and how they feel about this work.
- To establish what support social workers have received when working with families before a baby is born, or how they would like to be supported.

The aim and objectives have all been achieved within the confines of this small-scale study. The study provides an in-depth exploration of the experiences of social workers undertaking pre-birth assessments, including practitioners who have worked within nine of the twelve LAs in the region. Participants had varying lengths of experience in practice, spanning from NQSWs in their first-year post-qualifying, to social workers who had been in practice for more than a decade.

The findings of this research have raised several themes and ideas that add depth to and extend current knowledge around pre-birth social work practice. Whilst some of the findings mirror those already available within the limited research on pre-birth social work, they provide a more detailed understanding of some of these factors from the perspective of the social workers undertaking this work. The study has also highlighted some new findings which extend current knowledge and have implications for practice and policy.

The first findings chapter highlighted the complexity and distinctive nature of pre-birth social work. The factors which led to this complexity were multi-faceted. Foremost was the level of responsibility and pressure associated with the work; when judgements can have a profound, final, and potentially catastrophic impact on the lives of the families and children within days of a child being born. This chapter placed social workers in a position of uncomfortable power; with the knowledge that their work would have lifelong consequences for the children and families they were working with. Participants struggled with where to align themselves through the assessment process, feeling caught between the baby and the parents. This responsibility was being felt in a context of uncertainty, where usual pieces of the

assessment puzzle were missing; parenting capacity could not be tested, and the babies remained invisible throughout the assessment process. Participants talked about wishing there was a way to predict the future and their discomfort with making such life changing decisions without more concrete evidence of how parents may be able to meet the needs of *this* baby. This missing information left more space for lengthy histories to take centre stage and participants discussed struggling to balance past information and current assessments. On the contrary, participants were left wondering how to effectively assess parenting capacity for first time parents, although most had not undertaken a pre-birth assessment of this nature. This juxtaposition of the uncertainty of the assessment process with the finality and gravity of the decisions being made is a highly concerning finding, given the potential impact on children and families, that extends current thinking on pre-birth social work practice.

Another unique contribution to knowledge which was highlighted in this chapter is the 'taken-for-granted' nature of the work. Participants often did not recognise that pre-birth work was *intrinsically* complex, although they did recognise that it was different to other aspects of child and family social work. Whilst all participants agreed that pre-birth work had the potential to be complex, their view was that it was additional factors within situations or families that made the work more complex, rather than the factors that are inherent in all pre-birth assessment work. This finding suggests that there is lack of recognition of the complex, weighty and morally fraught decisions that are being made by social workers involved in pre-birth work. This is indicative of a 'taken-for-granted' attitude that the work is no more complex, nor ethically

and morally challenging, than any other aspect of child and family social work, which is a unique contribution to the current understanding of pre-birth practice. This was an idea further developed in subsequent findings chapters.

The second findings chapter explored how social workers attempt to get the 'right' outcome for this baby, and what they had to navigate in this process. This chapter brought to light wider concerns about the culture and systemic factors that can impact on decision making and outcomes for newborn babies. Individually, the participants all appeared passionate about advocating for the family and the unborn babies. With their understanding of the gravity of these decisions, they wanted to promote social justice and take measured risks to enable babies to remain in the care of their families where this was possible. Relationships were seen to be key to the work with families and participants discussed how they wanted to work with families in an open, honest, and relational way. At times participants discussed how their practice and decisions felt outside of their control. Within this chapter, social workers were positioned as powerless when faced with the systems, processes and organisations that impacted on their practice. Some participants spoke of their powerlessness when confronted with more senior colleagues who had a view that the outcome of their assessment should be different. Some also felt frustrated or angry about how the 'system' was letting families down through limited resources and options to support families. They also felt powerless to continue to support families following removal, when they could see this was a time that access to services needed to be increased, rather than decreased. This was again at odds with the relationship-based approach that they felt was needed within pre-birth practice. This findings chapter highlights ethical and

moral questions about the wider cultural, organisation and systemic impact on life-long decisions for children and families which are being made before a baby is born.

The final findings chapter highlighted how unprepared social workers are when completing pre-birth assessments and associated work. In lieu of any training or guidance, an approach to pre-birth assessment was ‘learned’ through a combination of reading colleagues’ work and through the experience of doing the assessments. All participants discussed completing pre-birth work early in their careers, either as newly qualified workers or in some instances, as student social workers. This left the participants in this study feeling anxious, fearful, and deskilled when completing their first pre-birth assessments. They were acutely aware of the consequences of their inexperience and wanted to make sure they were doing the work well, but the only means of doing this was through seeking advice in formal and informal supervision and reading previous assessments. The space left by a lack of clear support or direction meant participants turned to, and were influenced by wider cultural factors, organisational norms and practice wisdom to shape their practice, as other sources of knowledge were lacking. The unpreparedness of social workers undertaking pre-birth assessment raises significant ethical and moral questions regarding practice, due to the gravity of the work and the potential consequences for children and families. It appears that at present, families are being used as a training ground and social workers are learning what might work, and how to navigate pre-birth work, as they do it. This is not to place individual blame on social workers, certainly not those who offered their time to take part in this study, but to raise questions about how this can be

addressed systemically. The findings around the complexity of the work combined with the unpreparedness of social workers to undertake this suggest that a fundamental rethink is required for how pre-birth assessments are allocated, undertaken, and how decisions are made.

This chapter also explored the emotions attached to the work and all participants spoke of the emotive nature of pre-birth work. This was not always recognised in practice and some participants received more support than others. For some participants, their emotions were actively dismissed and undermined leading them to feel disillusioned and questioning their capacity to manage the work. The findings regarding how social workers prepare for the work and how their emotions are supported and managed again harks back to the 'taken-for-granted' nature of pre-birth practice; where there appears to be limited wider recognition of the high consequences of pre-birth work for children and families, but also for the social workers undertaking the assessments. The final findings chapter placed social workers undertaking pre-birth assessments as vulnerable, vulnerable to their practice being shaped into ways of working that are prominent in their organisations without the knowledge of different ways of working, and emotionally vulnerable to experiencing moral distress and ethical stress when unable to enact what they felt was 'right'.

These findings have met the aims of the study by exploring social workers understanding of pre-birth work and how this differs to other aspects of their role, considering the impact that this has on them and what support they receive with the work. The next section will explore the unique contribution to the current understanding of pre-birth practice offered by this research.

8.3. Original contribution to knowledge

The findings of this thesis position pre-birth assessment as complex, uncertain and highly consequential for all involved, whilst also highlighting a 'taken-for-granted' approach to the work. This has significant moral, ethical, practical implications for both children and families, and social work practice. It extends the current understanding of pre-birth practice, offering several original contributions to knowledge.

An uncertainty around pre-birth birth assessment is evident throughout the findings of this study which offers new insight into pre-birth social work. In contrast to other child and family social work assessments, there are usual elements of the assessment that are missing; the child remains invisible during assessment, and parenting capacity is untested, leading to decisions that are based on "educated guesswork". Lengthy histories of involvement had the potential to guide decisions, with social workers struggling to evidence or see how things could be different in the future when the child at the centre of the assessment is not yet born. Alternatively, for first time parents, social workers found it difficult to assess parenting capacity whilst the child remained invisible. Despite this, the decisions made in this period of uncertainty can be final. As explored within the literature review (Chapter 3), the impact of infant removal on parents is so profound and the chances of reunification can be low, and decision to remove a child can become self-reinforcing (Broadhurst et al., 2022). This calls for urgent attention to be paid to the uncertainty associated with the work and how this affects what outcomes should be pursued.

Adding to this uncertainty, a clear finding from the study is how unprepared social workers are to undertake pre-birth assessments; with learning being

experiential and informal. The findings of this research have identified that the current ways of 'learning' pre-birth practice are based on reading colleagues' previous work and through the experience of doing them, which leads to social workers feeling fearful and anxious but needing to "muddle through". This raises significant questions about the legal, ethical, and moral basis of both practice and decision making in pre-birth social work, with concerns that families are being used as a training ground for unprepared and ill-equipped practitioners to develop their ways of working. The decisions being made during and following pre-birth assessments are too profound for them to be made in a forum of such uncertainty using improvised approaches. This finding represents an entirely new, and concerning, perspective on pre-birth practice.

Adding to this, all participants spoke about doing the work early within their careers, as either students or newly qualified social workers. Many of the social workers in this study were highly uncomfortable with the potential impact of their inexperience as well as the missing aspects of the assessment and yet, it appears from the findings of this study that this is not questioned more widely in practice. Without realising, social workers are being asked to do highly complex and consequential work without adequate preparation which suggests a 'taken-for-granted' view that this is appropriate.

The uncertainty discussed so far adds to the complexity of the work. However, the findings of this study would suggest that there is limited recognition within organisations, and child and family social work holistically, that pre-birth assessment work is a unique and distinctly challenging area practice. There was individual recognition that the work felt different, but there was a disconnect between this and the inherent complexity of pre-birth practice. This

“taken-for-granted” approach leaves social workers coming into child and family social work have no basis to challenge the ‘status quo’, as they are unaware that things could be done differently. It risks them being inadvertently indoctrinated into cultures and systems that they are unable to see beyond; reducing their capacity to think critically about the practice they see and are involved in. The findings of this study have raised concerns about the impact of culture and organisational factors on decision making in pre-birth assessment. The literature review also highlighted significant regional variation in terms of outcomes of prebirth assessment (see Chapter 3, section 3.8), placing the North East of England as one of the areas with the highest rates of infant removal. Chapter 2 also explored the impact of decades of neoliberal ideology and over ten years of austerity measures on the North East of England alongside the rising numbers of child removal. Whilst increased deprivation and reductions in funding and resources linked to austerity could explain some increases in statutory intervention in the region, questions have been raised about how this could also be indicative of differences in culture within social work organisations (Bywaters, 2017; Roe et al., 2021). The findings of this thesis extend current thinking and highlight a need for wider attitudes towards pre-birth assessment to be challenged for positive change to be possible.

Within pre-birth work, social workers found themselves caught between the unborn child and the parents, but also between the child/family and the organisation/system. With the child at the centre of the assessment unborn and invisible when decisions are made before birth, this left social workers conflicted as to who their primary client was. Further to this, social workers

found themselves operating between the child/family and the organisation they worked for, or more broadly the child protection system. They found this balance between what they saw as the family's needs and what was available to them difficult to navigate, which added to the complexity and uncertainty within the work. As was explored in Chapter 2, there have been increasing concerns about risk averse practice in child and family social work, related to the impact of politics, policy and the influence of the media. Discussions in this chapter highlighted the vulnerability of social workers operating in a culture of blame and how this can lead to risk averse or fear-based practice. Whilst some participants mentioned being advised to think of the worst-case scenario from managers or supervisors, which may relate to a blame or risk averse work culture and the impact of managerialism, most presented as being directly opposed to risk averse practice or "risk-to-self averse" (Munro, 2019, p.125) practice. Rather than being concerned for themselves, their concern was their responsibility to avoid risk averse decisions which would be 'wrong'; where a newborn child is separated from their parents without this being warranted. This is contrary to prior research which has suggested social workers involved in pre-birth assessment are more likely to take a risk averse stance due to the pressure of defensive practice promoted by the current child protection paradigm (see Critchley, 2018; 2020a; Hart, 2011; Hodson, 2001). There was significant emotionality and moral distress associated enacting what some saw as risk-averse decisions, and when they were unable to enact what they believed to be the 'right' thing. This offers a unique insight into both risk-aversion and emotions around pre-birth practice.

Leading on from this, the emotionality of the work also presented as something that was unrecognised. As with the complexity and uncertainty, there was a ‘taken-for-granted’ undertone that social workers should be able to cope with the work, as it is neither more complex nor emotionally demanding than any other area of child and family social work. Both positive and negative emotions were evident throughout the study, but what was clear was that that pre-birth practice is fundamentally emotional in nature and that often these emotions could be challenging. Despite this, there was a sense that this was unrecognised at a broader organisational or systemic level. This again suggests that the complexity and moral dimensions of this area of practice are not universally recognised. These findings add depth to the current knowledge base around pre-birth practice where limited literature had explored the emotional components of practice, as explored within the literature review (see Chapter 3).

The points discussed within this section all relate to the assumptions made around pre-birth assessment. The findings of this thesis have placed pre-birth assessment as being intrinsically complex, fundamentally emotional, and highly uncertain; where the consequences for the children, families, and indeed the social workers undertaking the work, can be catastrophic. Yet they also suggest a ‘taken-for-granted’ attitude that the work is no more complex, uncertain, grave, nor ethically and morally challenging than any other aspect of child and family social work. This paradox is, in itself, a unique and novel contribution to the current understanding of pre-birth assessment work in social work. These findings offer distinctive contributions to knowledge and

have significant implications for practice, policy, research and education, which will be explored in the next section.

8.4. Implications of the findings

As this is a Professional Doctorate thesis, the implications for practice, management and policy are most pertinent. The focus of this study was social workers and the implications for them will be the main consideration of this section, although some of the discussion extends to their work with children and families.

8.4.1. Implications for practice, management and policy

The findings of this thesis have highlighted the uncertainty and 'taken-for-granted' attitude surrounding pre-birth practice. Whilst every piece of work with families carries great responsibility and situations are often complex, this thesis proposes that pre-birth work is inherently complex and the consequences for families, children, and indeed the social workers undertaking the work, are too significant for them not to be taken seriously. Therefore, several recommendations are made for practice.

There needs to be a fundamental change in the way pre-birth assessment work is viewed in practice. Whilst this was a small-scale qualitative study confined to the North East of England, it has raised significant questions about how pre-birth practice is perceived, approached and supported. A clear view throughout this thesis is how much is 'taken-for-granted' about pre-birth practice, whilst also positioning the work as intrinsically complex, highly uncertain, and fundamentally emotional. It indicates at an organisational and systemic level that pre-birth assessment is not recognised as being any more

complex nor ethically charged than any aspect of child and family social work. The analysis of the findings from this study challenges this assumption. For these ‘taken-for-granted’ views to be contested, there needs to be more conversation and dialogue around pre-birth practice as it appears this is something that is currently lacking. A change in attitude towards the work at individual, organisational and systemic levels is required, with recognition of the complex and consequential nature of the assessments.

The lack of guidance and training for pre-birth assessments has led to social workers developing their own ways of learning. The findings of this study support previous research which has made recommendations that the lack of guidance for pre-birth assessment needs addressing (Broadhurst et al., 2018; Critchley, 2018b; Hodson, 2011; Lushey, 2017) but offers a new insight into how social workers develop their approaches to pre-birth practice. The key ways of learning identified in this study were reading others’ work and through drawing on previous experience. This leaves ill-equipped social workers making highly consequential decisions that can have a significant impact on the unborn child and their family. This way of learning also leaves social workers doomed to repeat what has been done before and to accept ‘taken-for-granted’ ways of practising. It is important that ways of working incorporate several forms of knowledge and extend beyond the practice wisdom of teams, otherwise social workers will be unable to challenge assumptions and routine ways of working.

As outlined in the ‘implications for education’ (section 8.3.2) below, providing additional training for social workers to prepare them for this area of practice would offer additional resources and ways of thinking, and support

practitioners to develop their pre-birth assessment skills. In addition to this, LAs need to look at the resources available to support social workers with pre-birth work and that more detailed guidance about how to do pre-birth assessment is developed. Further guidance being produced by LAs would support social workers to consider what factors to include in the assessment, how to effectively assess parental capacity and capacity to change, the risks posed to unborn babies, and how to navigate some of the unique complexities of undertaking pre-birth assessments which were discussed in the first findings chapter (Chapter 4). Related to this is the use of research and evidence-based resources in practice. Participants in this study did not discuss using any research or resources to guide their practice. Whilst the research on pre-birth practice is limited at present, there is an increased focus on this area of practice with a growing evidence base; it is important that this is embedded within training or resources for social workers undertaking pre-birth assessment work. This is not suggested as a way of adding to managerial, bureaucratic, and procedural based thinking, but instead to promote critical thought, and to develop and share good practice within and between LAs.

In addition to how pre-birth practice is viewed, the uncertainty and missing information in the assessment process leads to questions as to how appropriate it is for these decisions to be made before a child is born. Whilst it would be beyond the scope of this research to suggest there are never situations where a decision to remove a newborn child might need to be made, the uncertainty of decision-making discussed within the findings suggests this requires further attention in both practice and policy. This combined with the increasing questions about the rising number of infants being born into care

(Alrouch, et al.; 2020; Bilson and Bywaters, 2020; Broadhurst et al; 2013; 2014; 2018; Broadhurst and Mason, 2020; Pearson et al., 2020; Raab et al., 2020) calls for urgent consideration of decision making in pre-birth practice. This study adds new information into the current discussion by uncovering how unreliable the pre-birth assessment process can be. Considering the wider context, Chapter 2 explored the wider socio-political and socio-economic context of child and family social work that pre-birth assessment sits within and the impact of neoliberalism on risk-averse and fear-based practice. For pre-birth assessment, this has legal, moral and ethical connotations. With the knowledge that only a small proportion of infants removed from their families shortly after birth are reunified (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Pearson et al., 2020), combined with the unreliable basis of pre-birth assessment work highlighted in this study, there is an urgent need for post-birth assessment to be more readily utilised. There is a shortage of parent and child placements nationally (Broadhurst et al, 2021) and there is limited availability of these placements within the North East of England. Policy and funding needs urgently revisiting to address this deficit.

Similarly, the inequality in wider support services has been highlighted in previous pre-birth research (Bilson and Bywaters, 2020; Broadhurst et al., 2018; Mason and Broadhurst, 2020; Mason et al., 2022a) which was explored in the literature review. Chapter 2 highlighted the differences in practice in the North East of England, some of which could be due to the impact of decades of neoliberal ideology and increasing levels of need in the area, but with questions being raised about the culture of practice within the region. Whilst the participants of this study did not discuss this directly, they did question the

services and resources available to them and families. They questioned whether the right outcomes were always available and how funding could be used to intervene at an earlier point in time or provide more structured support to families who had experienced removal. Whilst this is an area which has received increasing focus in recent years through the 'Born Into Care' series (Alrouh et al., 2019; Alrouh et al., 2020; Broadhurst et al, 2017; Broadhurst et al., 2018; Griffiths et al., 2020; Mason, et al., 2019; Mason and Broadhurst, 2020; Mason et al., 2022a; 2022b; Pattison et al., 2021), this study serves to further emphasise this from the perspective of social workers who have been involved in the assessment of unborn children and removal of new-born babies. Current practice appears to be very individually focused on the deficits of the family, which ignores the wider context of pre-birth practice explored in Chapter 2. It is important that social workers understand and take into consideration the wider socio-economic context and research around pre-birth practice. Without this understanding, they would be unable to challenge current cultural and organisational norms to work towards promoting and effecting change within their organisations.

The aspects of uncertainty, complexity and emotionality in pre-birth work all raise questions about how appropriate it is for student social workers, or newly qualified social workers to be undertaking this work. Participants within this study have suggested pre-birth assessments are often allocated to social workers early in their careers, sometimes as "learning opportunities" whilst at the same time recognising that they were unprepared for this. This harks back to the 'taken-for-granted' attitude towards pre-birth work which requires challenge. Given the complex nature and challenges of pre-birth practice

discussed throughout this thesis, consideration needs to be given to how appropriate it might be to allocate student social workers or NQSWs pre-birth assessments, especially without adequate practical and emotional support being put in place. In reality, this may be unavoidable, with increasing numbers of children and families' social workers leaving their roles and vacancies currently being at a five year high (DfE, 2021), meaning more complex work will likely be allocated to newly qualified staff. Where it is necessary to allocate pre-birth assessments to early career social workers, this study has evidenced the need for increased practical support and reflective supervision to support staff with their first pre-birth assessments, which will be discussed further within this section. Some participants talked about how co-working pre-birth assessments had supported them to develop their confidence in the work, which could be a supportive option for early career social workers, or those undertaking pre-birth assessments for the first time.

Another key area which emerged from this study is how social workers are supported emotionally to undertake pre-birth assessment. This is something that has not previously been explored in the literature in any detail, although there has been a recognition that support was important (Hodson, 2011), especially in instances of infant removal (Everitt et al., 2015; Marsh et al., 2019; Powell et al., 2020). For managers and supervisors, it is important that this uncertainty and discomfort is recognised and that social workers are given the time and space to reflect on their work in a safe, and non-judgemental space. There needs to be wider recognition that pre-birth assessments bring moral and ethical complexities which may result in social workers feeling conflicted, distressed or unsure, and they need to be able to discuss and

explore this in supervision, even when managers might not feel the situation would warrant such feelings. For social workers, further discussion about the complex and emotional nature of pre-birth practice may help them to recognise when they are struggling with the work and it is important that they feel able to discuss their concerns in a safe environment. Some of the participants discussed feeling as though they were unable to challenge decisions or take ownership of their own assessments, leading to high levels of moral distress. Safe and reflective supervision where these concerns could be heard, discussed and debated may have supported these individuals. As for all social work practice, critical thinking and respectful challenge needs to be a possibility in practice. For three participants, who all appeared passionate about the opportunities pre-birth can bring and caring and motivated to support families, the lack of recognition around emotions and closing down of conversations which may have promoted critical thought and reflection, contributed to them leaving their roles. Whilst this was a small-scale study and this finding may have been due to the sampling approach (see section 8.5), having such a high proportion of participants with similar experiences raises significant questions about the broader experiences of social workers. Further research would be required to establish a wider understanding of this (see section 8.4.3). However, the contributions of these three participants, and my own experiences, suggest there is an urgency to address the deficit in the support available to some social workers. Many participants highlighted that they believed additional supervision should be available for social workers working on complex tasks, such as pre-birth assessment and having separate supervision which focuses on reflection and emotions rather than tasks may

support social workers to process some of their feelings about the work without the distraction of the practical aspects of the work. This is in line with broader discussions of the impact of managerialism on supervision. Given the findings of this study, this is something that requires urgent consideration from organisations.

It is also important to discuss the positive aspects identified from this thesis and how these can be further developed in practice. At the centre of all work within pre-birth practice is an unborn baby and their family. Social workers in this study were passionate about being able to advocate on behalf of the baby and/or the family members. They discussed how relationships were key to their work and the positive impact that relational based practice can have. It is important for this to be given the time and space it requires for trusting relationships to be developed. As with earlier research which has explored pre-birth, a recommendation for practice from this is that pre-birth assessments need to be started earlier (Broadhurst et al., 2022; Broadhurst and Mason, 2013; Critchley, 2018b; Hart, 2001; Hodson, 2011, Mason et al., 2022a). The findings of this study support previous literature, which recommends LAs revisit their policies on pre-birth and adjust their timescales to start the work early within the pregnancy to enable this.

8.4.2. Implications for education

This study has highlighted that pre-birth practice appears to be absent from social work education and training, which is in keeping with findings from previous research (Hart, 2001; Hodson, 2011; Mason et al., 2019; Ward et al., 2012; Lushey et al., 2018). None of the participants in this study mentioned having received either pre-qualifying information on pre-birth assessment or

post qualifying continuing professional development (CPD) in this area. This study was only focused on one area of the UK, meaning that there may be other geographical areas where pre-birth assessment training is available. However, two of the participants in the study had experience of working in several other geographical areas and received no additional training, and the wider literature would indicate that this is not an issue isolated to the North East of England. The implications for practice, policy and management discussed earlier in this chapter made recommendations that the 'taken-for-granted' approach to pre-birth assessment is something that needs to change. For this to be possible, there needs to be wider discussion and debate about pre-birth assessment for social workers to be able to recognise the complexity, emotionality, and gravity that the work brings. These discussions and debates need to be embedded in social work education. Including teaching and learning around pre-birth assessment within pre-qualifying education would be challenging, as qualifying routes are designed to equip students with foundational knowledge and skills, and core social work values which can be further developed post-qualifying (Frost et al., 2013; Jack and Donnellan, 2010). Generally, specialist areas of training are seen as more appropriate for post-qualifying CPD (Staemphfli et al., 2015). In addition to this, the uncertainty, gravity and complexity of pre-birth assessment discussed in this thesis would lead to an argument that pre-birth assessments should be undertaken or supported by more experienced staff. Therefore, post-qualifying education may offer the best place for training on pre-birth practice. Ensuring training is available would help social workers to avoid the feeling of being "wildly underprepared" to undertake their first pre-birth assessment, increasing

confidence and reducing the conflict and stress associated with this feeling. In turn, this has the potential to improve the quality of the work and improve the experiences of the families that social workers are working with.

8.4.3. Implications for research

Whilst this study adds to the understanding of pre-birth assessment, it is clear from the scarcity of research available on the topic that further exploration on the topic is required. Given the growth of pre-birth practice across the western world, it would be useful to gain an updated understanding of the circumstances that lead to pre-birth assessment. Hart (2001) and Hodson's (2011) theses offer the most recent detailed research which considered the characteristics which led to pre-birth assessments in the UK. Their work also represents the most up to date studies which consider the quality of pre-birth assessment and their outcomes. The growth of practice in this area would warrant this research being updated for both the circumstances that lead to pre-birth assessments being undertaken, and the resulting quality of this work.

This study was narrow in its scope, only interviewing ten social workers from one region of England. The research has uncovered some significant findings which would warrant wider exploration, especially around the 'taken-for-granted' nature of practice and the uncertainty of assessment. Wider understanding of the experiences of social workers across the UK would offer a broader understanding of these concepts, where stronger assertions for practice, policy and education can be made.

Leading from this, further research which considers pre-birth assessment in a more holistic sense, rather than focussing on instances where removal was

recommended would give a clearer understanding of pre-birth assessment as a whole. As the literature review explored, much of the research currently available is skewed towards instances of removal, with very little being known about assessments which result in support under child in need, child protection, or referral to early intervention services. With this current gap in our understanding of the work, the evidence is focused more on extreme examples when there may be learning from work undertaken that does not result in removal. An appreciative inquiry into work with families where removal has not been recommended may highlight areas of good practice that could apply to all pre-birth assessment work.

Having put forward that we need more research which considers pre-birth practice more broadly, during this study participants were keen to discuss their experience of being involved in the removal of infants from their parents. Whilst the wider literature is skewed to more extreme examples where removal is recommended, the social workers perspective on infant removal is still lacking. The only research which looks at social workers' experiences of being involved in the removal of newborn babies from their families in depth was undertaken in Australia by Marsh et al. (2019) as part of a broader study which also included other professionals. Currently, there is more understanding of how midwives experience and navigate instances where removal at birth is recommended. Given the role that social workers play within this, it is important that their experiences are also represented more clearly in the literature in order to develop practice towards a holistic understanding of how all professionals experience pre-birth assessment to improve practice.

Participants in this study did not immediately recognise that pre-birth assessment was inherently a more complex task than any other aspect of child and family social work, and yet their discussions went on to explain all the ways that it can be more challenging. Further consideration of the ethical dimension of the work and how social workers make decisions about a baby that they do not know, with family situations that they cannot see and how they navigate this in their day-to-day work with families is required. The literature review highlighted a focus on compliance and engagement over evidence of capacity to change (Critchley, 2018b; Hard 2001; Hodson, 2011), however, there is some evidence to suggest that cooperation and compliance is a misleading factor in predicting desire or ability to change (Ward et al., 2010). Whilst participants in this study did not raise this topic, instead focusing on the quality of relationships with families, the literature review would suggest further research to understand this is required as no studies have explored this in any depth in relation to pre-birth practice.

8.5. Limitations

The limitations of undertaking a small-scale qualitative study within one area of England were explored within the methods chapter (Chapter 4). The study did not aim to be generalisable, but to highlight the experiences of social workers undertaking pre-birth assessment. In terms of sampling, the participants of the study were all volunteers who responded to emails distributed through their LA, or the flyer which was shared via social media. As with all studies utilising volunteers, there is a possibility the participants represent a sub-section of the population who have a vested interest in the topic. Volunteer sampling is not recommended when it is likely to lead to a

sample with a single experience or perspective (Liamputtong, 2013). To address this, I selected participants from those who volunteered with a wide range of experiences in terms of time qualified and LA that they had worked in. This resulted in participants who have differing experiences and views of pre-birth practice, rather than one homogenous viewpoint, and this is evident within the findings of the study. Four of the ten participants in the study were male, which I highlighted as unusual within the methods section. As no further information was taken from the participants about their motivation to partake in the study, this is unexplained, but it is worth noting that this is not representative of the population of children and families social workers as a whole.

Although this study aimed to explore social workers' experiences of pre-birth work holistically, there was a tendency for participants to focus on their experience of removals at times or discuss more difficult situations. I reflected within my findings that they may be due to emotive experiences being more likely to remain with participants (Kensinger, 2009; Cooper et al., 2019). I was aware this could be a possibility and designed my interview schedule to ensure a broad range of topics were discussed during the interviews including positive aspects of the work.

Whilst this study was focused on pre-birth assessment, at times it was difficult to differentiate between pre-birth practice and children and families practice more widely, meaning that there is some cross over between the findings and child and family social work more generally. During analysis I tried to ensure I was using sections of the interviews which were focused on pre-birth primarily, to maintain a focus on the research topic. Despite this, there are some areas

of the findings which extend beyond pre-birth assessment and participants spoke of the cumulative toll of having high and complex caseloads which included pre-birth assessments. Whilst this makes it more difficult to identify the impact of pre-birth assessments in isolation from other work, it reflects the reality of child and family social work practice within generic safeguarding teams; where there are many competing demands and involvement in pre-birth assessment adds to the complexity of the work.

8.6. Dissemination strategy

For this research to be useful for social work practice and education, it is important that it is disseminated. Dissemination has been ongoing throughout the time I have been working on this thesis, through my teaching at a local University. I was working within Higher Education when I started my doctorate journey, at a Further Education College delivering predominantly Higher Education on health and social care, and childcare degree programmes. In June 2020 I took up a post as a Senior Lecturer in Social Work at a local University and my role has afforded me the opportunity to discuss pre-birth practice with both social work students and qualified social workers. I now deliver sessions across all three of the qualifying social work routes offered at the University to help students start to think about the complexities of pre-birth practice, and to share current messages from research about this area of child and family social work before any of them will undertake a pre-birth assessment. The University also offers CPD to the local LAs and I have facilitated sessions with qualified social workers, allowing them the space from the demands of practice to reflect on their own experiences and share what is currently known about best practice in pre-birth assessment.

On completion of this thesis, my priority will be disseminating the findings back to the research participants, and other people who registered an interest in the study. My plan is to produce a summary poster which will be sent to all of the individuals who agreed that they wanted to know the outcome of the study on the Microsoft Form survey I used during recruitment (see Appendix D, section 10.5).

Having undertaken this research within the North East of England with social workers who have experience of practice within the region, disseminating the learning within the region to LAs, managers and practitioners is also important. Following the submission of the thesis a summary briefing paper will be produced and disseminated to LAs via Workforce Development Leads and/or Principle Social Workers. As part of this strategy, I will also offer to speak to LAs who would like to know more information about the research.

Following on from dissemination to the participants and others who registered an interest in the study, and LAs within the region, I intend to work on several articles and submit these for publication within academic journals. There are a number of areas of the literature review which have not been explored in published research; for instance, some of the information about how pre-birth assessments are undertaken and the current understanding of this. It would be worthwhile to pursue publication of some of these elements to inform the wider knowledge base around pre-birth. My findings chapters add depth to the current understanding of pre-birth practice from social workers' experiences and perceptions, as well as providing an original contribution to the current knowledge base. Several journal articles could be developed from the findings and some of these are detailed below:

- Article on the impact of invisibility of the child in pre-birth social work practice
- Article exploring how unprepared social workers feel for pre-birth practice and what impact this has on both them and their work.
- Article discussing the uncertainty in assessment and decision making in pre-birth practice and the implications of this for children, families and social workers.
- Article exploring the dichotomy of working with families during pregnancy, with a divided focus between the family and the unborn baby.
- Article exploring the emotions around pre-birth assessment and the potential for moral distress.

Another way of disseminating the findings of this study would be to attend conferences. The first step towards this will be presenting in the monthly research conference at the University I work at. Following this I will identify external conferences which might be relevant for the topic, such as the Joint University Council Social Work Research and Education Conference, or the European Conference for Social Work Research with an aim to present some of my findings in 2023-2024.

8.7. Final Reflection and Conclusion

The topic of pre-birth is something that has maintained my focus for over three years, but as I finished this thesis, I feel I have more questions than when I started it. As a social worker in practice, I had not reflected on how complex the work was and how difficult it can be to make judgements about a child's future before they are born. My focus was doing the work and trying to do this

well, something that also resonated with the participants in this study. Taking a step back from *doing* the work and spending so much time *thinking* about the work over the duration of this thesis has led me to realise just how complex and uncertain the work is, and how much is taken for granted in pre-birth practice. The findings of this study have extended far beyond my expectations. Entering this study, I had hoped to find a more encouraging picture of pre-birth practice that could be built upon and shared. Instead, I have situated pre-birth practice as intrinsically complex, fundamentally emotional, and highly uncertain; where the consequences for the children, families and social workers can be catastrophic, and yet appear to be broadly unrecognised. This is something that requires urgent attention in practice, education, policy and research. As with my own reflections on my experience, the social workers taking part in this study wanted to do the work well. They wanted to be able to practise in relational ways that provided support to families so that they are afforded every opportunity to care for their unborn child after birth. With this in mind, I would like to relay Lonne et al.'s (2009) thoughts on child protection policy, that "it is the paradigm that is in question, not the people" (p.7). The issues raised in this thesis are not aimed to undermine the work of social workers within the region but promote reflection and critical thought around how practice can be developed. The participants' openness and reflections have uncovered the complex and uncertain nature of pre-birth, my hope is that bringing these to light will promote the change that is needed at broader levels to address the current deficits; to improve practice for social workers and improve the experiences of the children and families they work with. This thesis is concluding at a time when there appears to be a growing focus on

pre-birth practice. It is hoped that the findings of this study will add depth and new insight to the current understanding of pre-birth social work and contribute to the development of practice in this area. For me, this thesis only marks the beginning of my work researching the topic of pre-birth social work practice as I remain invested in ensuring that social workers are equipped to support families during pregnancy and beyond.

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10. Appendices

10.1. List of Appendices

10.2. Appendix A: Ethics application

Ethical Approval for Non-Clinical Research Involving Human Participants

FORM B: Application for ethical approval for medium/high risk projects

Name of Applicant	Calysta Anne Bleasby
School	Education and Social Work
University e-mail Address	c.bleasby@dundee.ac.uk
Title of Project	The impact of pre-birth assessment work on social workers
Co-Investigators (with internal School or external organisational affiliation)	N/A
Projected Start Date	June 2021
Estimated End Date	December 2022
Funder (if applicable)	N/A
Version of Application (1, 2, 3…)*	2

* After revision, please update the version number before re-submission.

Students Only	
Level of Study (Undergraduate (UG); Taught Postgraduate (TPG); Research Postgraduate (RPG)	Taught Postgraduate
Name of University of Dundee Supervisor	Mark Smith and Maura Daly

Note: Students must copy in their supervisor when submitting the application for review.

1. Project Information

1a. Please provide, with reference to the relevant literature, an overview of the research project providing a short explanation maximum 400 words) of the research questions the project will address and why the study is justified.

Pre-birth assessments are assessments undertaken within a children's and families' social work context. They involve social workers as part of a multi-disciplinary team and focus on assessing potential risk of harm to unborn babies (Critchley, 2018). Pre-birth assessments were first introduced to social work practice in the 1970s (Fairburn and Tredinnick, 1980). The number of pre-birth assessments is rising, with evidence of significantly increasing numbers of assessments and interventions during the pr-birth period between 2008-2016 (Broadhurst et al, 2018). Despite this increase, pre-birth assessment remains an area of practice which is significantly lacking in academic research (Critchley, 2020; Hart, 2002; Hodson, 2011; Mason, Robertson and Broadhurst, 2019).

The evidence base for pre-birth assessments is limited, with many Local Authorities utilising models proposed by Hart (2001) or Calder (2003). These approaches have never been reviewed or critiqued (Hodson, 2011) and there is a strong argument that the model needs updating (Critchley, 2018; Lushey et al., 2017). This can lead to practitioners forming their own methods of completing assessments and significant variation in practice being clear across England (Mason and Broadhurst, 2020). There is emerging evidence that there is a tendency towards risk averse practice within pre-birth assessment, and that social workers may recommend removal of a child as a safer option to allow more time for assessment (Critchley, 2018; 2020) which goes against legislation and guidance which state

that newborns should only be removed for extraordinary and compelling reasons (Council of Europe, 2015)

The experiences of those involved in pre-birth assessments is a clear gap within the literature, when considering both families and professionals. There is some limited literature around the experiences of family members, with two UK studies having explored this (Corner, 1997; Critchley, 2018; 2019). Further articles explore the experiences of removal within the first week of birth (Broadhurst and Marson, 2020; Marsh, 2016; Marsh et al., 2019) but the impact on families is still relatively unexplored. Even less is known about the experience of professionals involved in pre-birth assessment work. Currently there is more literature available on the experiences of midwives involved in pre-birth child protection work (see Everitt er al, 2015; 2017; Marsh, 2016; Marsh et al, 2014; 2020, Marsh et al., 2019), although this research tends to focus on removal at birth rather than assessment more holistically. Research that focuses on the social workers experiences is extremely limited. Critchley's (2018) thesis and a subsequent publication (Critchley, 2020) discuss some aspects of the experience of social workers involved in pre-birth assessment work in Scotland. Marsh et al. (2019) also explored the experiences of social workers involved in removal of babies at birth in Australia, however the processes around removal are very different in England and Australia.

The focus of this research is to explore the experiences of social workers undertaking pre-birth assessment work and to consider the impact that this has on them, both personally and professionally. The research will also explore social workers' understanding of pre-birth assessment and how they feel about completing them, exploring some ideas around inconsistencies in guidance and processes used by social workers outlined above. This research will focus on the English context, building on the work of Critchley (2018, 2020) and Marsh et al. (2019)

1b.What are the aims and objectives of the project?

The aim of this research project is to develop an understanding of the experiences of social workers undertaking pre-birth assessment work, and to explore the impact that this work has on them both personally and professionally, whilst also considering how they deal with this.

The objectives are as follows:

- To explore social workers' understanding of pre-birth assessments and how these relate to other aspects of children's and families' social work.
- To ask about their experiences of undertaking pre-birth assessments within their role
- To explore what impact this work has had on them, both personally and professionally
- To establish how they have been supported to complete these assessments, or how they would like to be supported.

1c. Please describe the design of your study and the research methods including information about any tasks or measuring instruments (validated or otherwise) that you will be using.

This study will be qualitative in nature and will involve a single phase of semi-structured interviews with social workers who have experience of pre-birth assessment.

The prompting interview questions are attached with this application and centre around the aims and objectives of the study, outlined above.

It is anticipated that the interviews will last around an hour, although some may take longer. The interviews will either take place in person, in a private room at a location of the participant's choosing, or online via Teams. This will be dependent on both Government and Organisational guidance regarding Covid-19. It would be preferable that the research was undertaken in person due to the potentially sensitive nature of some of the discussion points.

2. Participants

	YES	NO
2a. Will your research involve children under the age of 16[1]?*		x
2b.Will your research involve the recruitment of vulnerable participants (for example, participants with learning difficulties, disabilities, members of marginalised communities, people involved in illegal activities such as drug abuse?*		x
2c. Will your research involve participants with communication difficulties, including difficulties arising from limited facility with the English language?*		x
2d. Will your research involve participants in unequal relationships with the researcher(s) (e.g., your own students)?		x
2e. Will your research involve participants outside of the UK?		x

* If you answered YES to question(s) 2a, 2b or 2c please attach a copy of your Protecting Vulnerable Groups (PVG) clearance from Disclosure Scotland (or the equivalent in other jurisdictions).
Please explain in detail how you intend to recruit your participants (including inclusion and exclusion criteria and the participant's location if outside the UK). Pay particular consideration to any issues arising from answering YES to any of these questions:

I intend to recruit participants by emailing workforce development leads for Local Authority children and families services, asking that they forward my email to any relevant teams who may be involved with pre-birth assessments within the Local Authority. I will be contacting Local Authorities which are local to my own geographical location.
The email will include the participant information sheet as well as a brief outline of the research with my contact details for interested participants to get in touch.

Through a process of snowball sampling, participants who hear about the study through word of mouth from other professionals will also be considered. These potential participants may be social workers who have left front line children's and families' posts to work in other areas of social work, where they may not receive my email from their workforce development leads. They may also be social workers who have previously been involved in pre-birth assessment but have subsequently left the profession who may be notified of the research by those who are still in practice and received my email.

In total I would be seeking a maximum of 10 and a minimum of 8 participants for the interviews. If I receive more expressions of interest in the research than I require, purposive sampling will be used to ensure a variety of geographical areas and level of experience are included within the final sample to draw on a range of experences. If there are not enough expressions of interest in the study, further efforts will be made to recruit participants through follow up emails to be shared by workforce development leads.

Inclusion criteria:

- Practising social workers (either current or previously)
- Experience of at least one pre-birth assessment during practice

Exclusion criteria:

- Other professionals without a social work qualification
- No experience of a pre-birth assessment

3. Informed consent

	YES	NO
3a. Will all participants be fully informed why the project is being conducted and what their participation will involve, and will this information be given before the project begins?	x	
3b. Will every participant be asked to give written consent to participation?	x	
3c. Will all participants be fully informed about what data will be collected, where and for how long it will be stored, and their rights under data protection legislation?	x	
3d. Will all participants be informed who has access to their data during the time it is stored?	x	
3e. If the project involves audio, video or photographic recording of participants will explicit consent be sought?[2]	x	
3f. Will every participant understand their right not to take part or to withdraw themselves and their data from the project without giving a reason and without penalty?	x	
3g. If the project involves deception or covert observation of participants will you debrief them at the earliest possible opportunity?		N/A
3h. Will participants be fully informed about the potential reuse of their data by other researchers?		N/A
3i. If required, will you obtain permission from relevant authorities (e.g. employers, third sector organisations, government institutions) as part of the recruitment process?	X	
3j. Are you satisfied that all participants have capacity to make their own decisions and understand the risks?	X	

If you answered YES to ALL of these questions please explain briefly how you will implement the informed consent scheme. *Please attach copies of the participant information sheet(s) and consent form to your application.*

There will be full clarity about the aims and objectives of the study from the first point of contact with any prospective participants and this is clearly outlined on the participant information sheet (attached with this application). I will also summarise the key points at the start of each interview and answer any questions participants might have, either

before, during or after the interview has taken place. Interviews will be digitally recorded, this has been addressed below.

Written consent will be sought from all participants prior to their interviews and these forms will be stored securely on the University systems through One Drive for the required period of 10 years, in accordance with University policy. Participants will be made aware that all information relating to the research project will be held securely on University systems and deleted from any devices. Participants will also be given an outline of the interview schedule ahead of the interviews to allow them to make an informed decision about taking part in the study. This will not include follow on prompts, but will cover the main questions which will be asked during the interview. The interview schedule has been submitted with this application.

The interviews will be recorded so that they can be transcribed, and transcription will be carried out solely by the primary researcher with no-one else having access to the recorded interviews. Participants will be asked to consent to the recording verbally at the start of the interview. They will also be informed that the recording can be stopped at any point during the session. If a participant does not wish to be recorded, they will not be able to be included within the study. The requirements of the study are clearly outlined on the participant information sheet and consent for in order for the participants to be able to make an informed decision about this prior to agreeing to take part.

Participants will be able to withdraw from the research at any time. The participant information sheet emphasises that all participation is voluntary, and consent can be withdrawn at any time. If they decide to withdraw from the study, any information they have shared will not be included and any recordings/transcripts will be deleted.

Participants will be given the option to receive a copy of the transcript after transcription. to verify authenticity. They will still be able to withdraw consent at that time if they wish to do so and their information will not be included within the study. This has been included in the participant information sheet, which is attached with this application.

If you answered NO to ANY of these questions, please provide an explanation. Please note that if written consent is not obtained, any other form of consent used must involve a deliberate action to opt-in (for example, in surveys or questionnaires).
Please attach a copy of the participant information sheet and consent form (where applicable) to your application.

See attached participant information sheet.

4a. Data Management: Lawful Processing of Data

1) Data protection legislation[3] requires participants to be informed of the lawful basis for processing their personal data. At the University of Dundee, the normal basis for the lawful processing of personal data in research is that 'processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller'. If you intend to use another lawful basis you must contact the University's Data Protection Officer (DPO) for advice and insert the lawful basis agreed with the DPO below.

Personal data will only be collected for the purpose of consenting to take part within the study. Consent forms may be digital or in hard copy depending on whether the interviews can go ahead in person, or are required to be online due to Government Covid-19 guidance. If consent forms are in hard copy, these be scanned and uploaded to the University's secure network on OneDrive as per the University guidelines for data storage. Similarly, digital consent forms will be stored in the same way.

2) In addition to the lawful basis above, where the research involves the processing of special category[4] (sensitive personal) data, participants must be informed of the specific condition under which this processing will be performed. At the University of Dundee, the specific condition for the lawful processing of special categories of personal data in research is normally that 'processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes'. If you will be processing special category data and intend to use another condition you must contact the University's Data Protection Officer (DPO) for advice and insert the condition agreed with the DPO below.

No sensitive personal data will be routinely collected during this study other than how long participants have been in practice.

Personal information might be disclosed during the interview regarding places of work, services or details about children and families. All of these details will be fully anonymised and replaced with terms such as [service], [local authority], [mother], [child] during the transcription process. Interviews will be stored securely and then deleted once transcribed, as outline below within section 4b. This will ensure that any personal data disclosed during the interview process remains secure until anonymised.

4b. Data Management: Planning

	YES	NO
4a. Are there any reasons why you cannot guarantee the full security and confidentiality of any personal or confidential data collected for the project?		x
4b. Is there a possibility that any of your participants, organisations they are affiliated with, or people associated with them, could be directly or indirectly identified in the outputs from this project?	x	
4c. Will any personal or confidential data be retained at the end of the project other than in fully anonymised form?		x
4d. Will it be possible to link information or data back to individual participants in any way (include consideration of the use of secondary data)?		x

If you have answered YES to ANY of these questions, please explain why it is necessary to breach normal ethical procedures regarding confidentiality, security and/or retention of research data.

As discussed within section 4a(2) there is a possibility that participants may disclose information about families that they have worked with, and organisations/services that may be identifiable if not anonymised. As explained above, any details will be anonymised

during the transcription process to remove any identifiable names or features. If participants outline details about families that they have worked with which may make the specific family identifiable due to the level of detail, this will be reduced to basic terms and generalised to remove any identifiable features. For instance, I will use generic terms such as mother, father, unborn child, infant. Any specific issues that the families have experienced will also be referred to in broad terms, such as substance misuse, domestic violence, mental health issues. My approach will be to enable deniability were any possibility of identification might arise.

There is a possibility that participants may have been involved with high profile cases where these cases could be identifiable. If this were to happen then the case details would be dealt with as outlined above, but I would also discuss any concerns with my supervisors should this issue arise.

Irrespective of your answers to questions 4a to 4d, please describe your plan for managing the data[5] you will collect during your project and how it complies with data protection legislation. Include information on: i) The type and volume of data[6]; ii) Where and for how long will the data be stored and what measures will be in place to ensure secure storage[7]; iii) Whether the data will be anonymised or pseudonymised[8]; iv) How secure access will be provided to data for collaborators; v) Whether and how data will be shared for reuse by other researchers beyond the project (including details on any access restrictions); vi) Processes in place to erase and/or stop processing an individual participant's data (except where this would render impossible or seriously impair the research objectives)[9]; vii) Processes in place for individuals to have inaccurate personal data rectified, or completed if it is incomplete; viii) Who has overall responsibility for data management for the research project; ix) Arrangements for collection and transfer of data outside the UK.

A formal data management plan has been created using DMP Online.

- Personal identifying information of participants will only be captured on consent forms, which will be stored securely on the University password-protected network via OneDrive with any original physical copies shredded and disposed of in confidential waste, and any digital original copies deleted from all devices.
- Following the interviews, participants will be allocated aliases and these pseudonyms and actual names will be recorded on a password protected website which will be stored on the University network via OneDrive. The file will not be stored on any personal devices or any other networks and I will be the only person with the password for the document. This document will be destroyed when my Professional Doctorate is awarded.
- Any names of other professionals or service users which are raised during the interviews will be anonymised during transcription by being allocated a pseudonym. Any further details such as names of places or services will be changed or removed to ensure the anonymity of any participants.
- Interviews will be recorded using a device such as a laptop, but the files will be password protected until they can be securely uploaded to the University network and stored on OneDrive. They will remain password protected even once they are on the University system and will then be deleted from the device.
- Digital recordings of interviews will be deleted as soon as the final transcripts have been completed and anonymised.

- Analysis of data may be undertaken outside of the University system but this will be fully anonymised and would not be linked back to any personal data. However, participants may withdraw from the study at any time, and their data will be deleted, where it is identifiable.
- Confidential data including consent forms and contact details will be kept for up to three years so that participants can be contacted during this time. It will be destroyed as soon as my Professional Doctorate is awarded.
- Anonymised transcribed data and analysis may be stored for up to 10 years in line with the University policies and procedures.
- All data will be kept confidential unless for some reason I am required to produce it by law or concerns arise during an interview about potential harm to any participants. In these instances I will discuss with my supervisor what action is to be taken.
- Data will not be shared for re-use beyond the project or transferred outside of the UK.

5. Risk of harm to researchers and participants

	YES	NO
5a. Is there a risk that the project may lead to physical discomfort or pain for the participants?		x
5b. Is there a risk of emotional or psychological distress to participants?	x	
5c. Will your research involve the use of tissue samples (including blood and biopsies from healthy volunteers) excluding use for genetic analysis only or tissues obtained from a tissue bank?		x
5d. Will the research involve psychological intervention?		x
5e. Will the research involve working with any substances and/or equipment which may be considered hazardous?		x
5f. Will the study involve discussion of sensitive or potentially sensitive topics (e.g., sexual activity, drug use, personal lives)?		x
5g. Is there a risk that the safety of the researcher may be compromised (e.g., lone working, working in potentially dangerous environments), i.e. does the research incur a risk of injury or ill-health above the level of risk prevalent in daily living?		x
5h. Does the research involve fieldwork outside the UK?		x

If you answered YES to ANY of these questions, please explain the nature of the risks involved, why it is necessary to expose the participant or researcher to such risks, how you propose to assess, manage and mitigate the identified risks and how you plan to communicate the risks and your plans for mitigation to the participants. Please also explain the arrangements you will make to refer participants or researchers to sources of help or advice if they are distressed or harmed as a result of taking part in the project. *Where the research incurs a risk of injury or ill-health above the level of risk prevalent in daily living the relevant risk assessment form(s) (general risk assessment form and/or the risk assessment for Travelling on University Work Overseas) should be submitted with this application.*

Discussing experiences of practice can be upsetting and distressing. Some participants may have been involved in the removal of infants or have experience of children being harmed during their involvement.

It will be made clear to all participants at the start of the interviews that they can pause or stop the interview at any time, should they need to take a break or no longer wish to participate.
As a social worker myself, I am experienced in speaking to people about emotive topics. I would be able to recognise clues that the conversation may be too difficult, and I will not continue the line of conversation unless the participant is certain they wish to do so. If any participant becomes distressed, they will be offered an opportunity to move onto a different topic or take some time out. Participants will also be able to see the content of the interview ahead of time as the interview schedule will be shared ahead of time. This will allow participants to opt out of the study if they feel that discussing the topics would have a detrimental effect on their wellbeing.

Should any participants become distressed, I will discuss with them who their best source of support would be and direct them to speak to their supervisors where appropriate. A list of all NHS talking therapy support services has also been compiled and can be shared with participants if they show distress during the interview. The list is attached with this application.

6. Risk of disclosure of harm/potential harm or of criminal offences

	YES	NO
6a. Is there a risk that the study will lead participants to disclose evidence of previous criminal offences, or their intention to commit criminal offences?		x
6b. Is there a risk that the project will lead participants to disclose evidence that children or vulnerable adults are being, or have been, harmed, or are at risk of harm?		x
6c. Is there a risk that the study will lead participants to disclose evidence of serious risk of other types of harm?	x	

If you have answered YES to ANY of these questions please explain why it is necessary to take the risk of potential or actual disclosure and what actions you would take if such disclosures were to occur. Please explain what advice you would take from whom before taking these actions and what information you will give participants about the possible consequences of disclosing such information.

Participants will discuss instances where they have been involved with children and families where there has been risk of harm. The cases that the participants discuss will have been managed under statutory guidance and legislation and dealt with in a way that ensures any children or vulnerable adults are protected from further harm.

It Is unlikely that any new information that raises concerns about harm to children or vulnerable adults but should this issue arise I will discuss this with my supervisors before taking any further action.

7. Payment of participants*

	YES	NO
7a. Do you intend to offer participants cash payments or any other kind of inducements for taking part in your project?		x

7b. Is there a possibility that such inducements will cause participants to consent to risks that they might not otherwise find acceptable?		N/A
7c. Is there any risk that the prospect of payment or other rewards will systematically skew the data?		N/A
7d. Will you inform participants that accepting compensation or inducements does not negate their right to withdraw from the study?		N/A

* Typically small sums or vouchers to compensate participants for out of pocket expenses such as travel and subsistence and for time spent/inconvenience.
If you have answered YES to ANY of these questions, please explain the nature of the inducement or amount of payment you will offer and the reason why it is necessary to offer inducements. You should also explain why you consider it ethically and methodologically acceptable in the context of this study to offer such payments or other inducements.

N/A

8. Voluntary participation

	YES	NO
8a. Will you recruit students or employees of the University of Dundee or of organisations that are formally collaborators in the study and who will be in an unequal relationship with you or the researchers affiliated with the project?		x
8b. Will you recruit participants who are employees recruited through other businesses, voluntary or public sector organisations?	x	
8c. Will you recruit participants who are pupils or students recruited through educational institutions?		x
8d. Will you recruit participants who are clients recruited through voluntary or public services?		x
8e. Will you recruit participants who live in residential communities or institutions?		x
8f. Will you recruit participants who may not feel empowered to refuse to participate in the research?		x

If you have answered YES to ANY of these questions please explain how your participants will be recruited and what steps you will take to ensure that participation in this project is genuinely voluntary.

I intend to recruit participants by emailing workforce development leads for Local Authority children and families services, asking that they forward my email to any relevant teams who may be involved with pre-birth assessments within the Local Authority. I will be contacting Local Authorities which are local to my own geographical location. I will not make direct contact with any individual professional (other than the workforce development leads) unless they contact me.

The email will include the participant information sheet as well as a brief outline of the research with my contact details for interested participants to get in touch.

Participants who hear about the study through word of mouth from other professionals will also be considered and will be contacted if they get in touch via my contact details.

The study will not be focused on only one Local Authority and there is no incentive for any participants to partake, other than their own interest in the topic.

Participants will be able to withdraw from the study at any time, without any penalty.

9. Any Other Ethical Considerations

Are there any other ethical considerations relating to your project which have not been covered above? If so, please explain.

N/A

10. Documentation

Please list all attached documentation, ensuring that each item has a date and version number.

Participant Information Sheet – V.2 - 17.05.21
Informed Consent form – V.2 - 17.05.21
Interview schedule – V.1 - 20.04.21
List of talking therapy support services – V.1 - 20.04.21

11. Declaration

By signing below I declare that I have read the University Code of Practice for Non-Clinical Research Ethics on Human Participants and that my research abides by these guidelines. I understand that this application and associated documents will be retained by the University.

Principal Investigator or Student

Name: Calysta Bleasby Date: 17th May 2021

Signature:

Supervisor (for applications from students)

Name: Mark Smith Date: 15th May 2021

Signature: *Mark Smith (to be taken as signature in absence of electronic signature – MS)*

10.3. Appendix B: Participant information sheet

Participant Information Sheet for Social Workers
The impact of pre-birth assessment work on social workers
University of Dundee School Research Ethics Committee
Application/Approval Number: E2020-112

You are invited to take part in a research project. Before you decide whether or not you would like to participate it is important that you read the information provided below. This will help you to understand why and how the research is being carried out and what participation will involve. Please let the researcher who gave you this information know if anything is unclear or you have any questions.

Who is conducting the research?

The research is being conducted by Cally Bleasby, a post-graduate student on the Professional Doctorate of Social Work programme at the University of Dundee. The research will be part of the fulfilment of the Doctorate programme.

Email: c.bleasby@dundee.ac.uk

Who is funding the research?

This research is not being externally funded.

What is the purpose of the research?

The purpose of this research is to explore the experiences of social workers undertaking pre-birth assessment work and the impact that this has on them. This is an area where very little research has been undertaken, and it is hoped that the research will provide further understanding of how social workers can be supported to undertake work with families during pregnancy.

Why have I been invited to take part?

You have been invited to take part because you have been involved with pre-birth assessments during your time as a social worker. As such, your experiences will help us develop a greater understanding of this area and influence future practice and guidance.

Do I have to take part?

No. Participation in this study is entirely voluntary and choosing not to take part will not disadvantage you in any way.

Should you choose to take part, you are able to withdraw from the study at any time without explanation or penalty. This can be done by emailing the researcher on the details above.

What will happen if I take part?

You will be invited to take part in an individual interview with the researcher. This interview should last no more than an hour. The interview will either be conducted face to face in a location of your choosing, or via Microsoft Teams, depending on the current Covid-19 guidance. During the interview you will have the opportunity to take breaks as required or end the interview without being required to give a reason.

The interview will be audio recorded and will only be accessed by the researcher.

Are there any risks in taking part?

Discussing topics around your experiences of practise can be emotive. You will not be pressured to discuss anything that you do not want to and are able to take breaks whenever you wish to do so. Information is available on support services within the local area if you would like to access any additional support around the topics raised during the interview.

What are the possible benefits of taking part?

Whilst there are no direct benefits to you for taking part, by taking the time to share your thoughts and experiences you will be developing the knowledge base around pre-birth assessment work. This will help to develop social work practice for yourself and/or for others, as well as inform future research, policy and guidance.

Will my taking part in this project be kept confidential?

All personal data will be kept confidential (except in circumstances where confidentiality must be breached - see below). This means that no information that could possibly identify you will be disclosed to others such as names, location or services. Confidentiality will be maintained through the careful storage of data and the anonymising of data used within the dissemination of the research. Recordings will be transcribed by the researcher and anonymised before being destroyed.

There are circumstances under which confidentiality can be breached. Confidentiality will be breached if you make a disclosure of risk of serious

harm to yourself or others. If confidentiality needs to be breached, we will discuss this with you first.

What will happen to the information I provide?

All data will be stored securely on the University of Dundee's network and confidential information will be password protected, with only the researcher having the password. The data will be stored for up to three years or until the completion of the Professional Doctorate programme and will then be destroyed. The data will not be shared with any other researchers.

If you choose to withdraw from the study, your data will be destroyed and will not be included in the final work. You are able to request a copy of the interview transcript from the researcher following the interview to review for accuracy. You can do this by emailing the research. If you wish to withdraw after reviewing the transcript you can do this without penalty and your data will be destroyed and will not be included in the final work
The anonymised findings from this research will be reported in a Thesis and may also be reported in a scientific journal or presented at research conferences. The information you share may be presented as anonymous quotes within the text.

You can access the published results by request to the researcher or through the University's repository (subject to any publisher requirements).

Data Protection

Your name will be collected for the purpose of consenting to the study. Personal data might be discussed during the interview which includes services and organisations, families you have worked with and their characteristics, colleagues and other professionals. All this information will be anonymised fully during transcription and no personal data will be processed.

The University asserts that it lawful for it to process your personal data in this project as the processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.

The University respects your rights and preferences in relation to your data and if you wish to update, access, erase, or limit the use of your information, please let us know by emailing c.bleasby@dundee.ac.uk. Please note that some of your rights may be limited where personal data is processed for research, but we are happy to discuss that with you. If you wish to complain about the use of your information please contact the University's Data Protection Officer in the first instance (email: dataprotection@dundee.ac.uk). You may also wish to contact the Information Commissioner's Office (https://ico.org.uk/).

You can find more information about the ways that personal data is used at the University at: https://www.dundee.ac.uk/information-governance/dataprotection/.

Is there someone else I can complain to?

If you wish to complain about the way the research has been conducted please contact the Convener of the University Research Ethics Committee (https://www.dundee.ac.uk/research/ethics/contacts/).

Alternative formats

Alternative formats of this form can be accessed by emailing c.bleasby@dundee.ac.uk

10.4. Appendix C: Informed consent form

University of Dundee

Informed Consent for "The impact of pre-birth assessment work on social workers"

	Yes	No
1. Taking part in the study		
I have read the Participant Information Sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	☐	☐
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time during data collection, without having to give a reason.	☐	☐
I understand that taking part in the study involves an interview which may last up to an hour and will be digitally recorded.	☐	☐
I understand that taking part in the study may involve discussing topics that may be upsetting for me and that if that is the case I should speak to the researcher in the first instance	☐	☐
I understand that if I raise any concerns about potential harm to either myself or others, that these will need to be shared in line with legislation and policy.	☐	☐
2. Use of the information in the study		
I understand that information I provide will be used for the researcher's thesis and possibly published journal articles and conference papers.	☐	☐
I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the primary researcher.	☐	☐
I agree that anonymised direct quotes can be used in research outputs.	☐	☐

3. Signatures

_____	_____	_____
Participant's Name	Participant's Signature	Date

By signing above, you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

_____	_____	_____
Name of Researcher	Signature of Researcher	Date

For participants who have difficulty reading the Participant Information Sheet and Consent Form, and/or signing the consent form, there is an alternative form of gaining informed consent.

_____	_____ *[researcher completes participant's name and date]*
Participant's Name	Date

☐

University of Dundee

Participants unable to sign their name should mark the box instead of signing

I have accurately read out the Participant Information Sheet and Consent Form to the potential participant. To the best of my ability, I have ensured that the participant understands what they are freely consenting to and have completed the Consent Form in accordance with their wishes.

Name of Researcher	Signature of Researcher	Date

I have witnessed the accurate reading of the Participant Information Sheet and Consent Form with the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Name of Witness	Signature of Witness	Date

If the participant is unable to mark the box but is able to indicate consent orally, or in another manner, then the signatures of the witness and the researcher will be sufficient. In such cases the researcher should indicate below how consent was given:

Form of consent for participants unable to provide a signature or to mark the box:

4. Study contact details for further information

For any further information please contact the researcher:

Cally Bleasby – c.bleasby@dundee.ac.uk

5. Alternative formats

Alternative formats of this form can be accessed by emailing c.bleasby@dundee.ac.uk

10.5. Appendix D: Microsoft forms sign up survey

Full form available at: https://forms.office.com/r/BdqbE5BPHR

Research study: The impact of pre-birth assessment work on social workers

Thank you for your interest in my thesis research.

Despite evidence that pre-birth assessment work is increasing in social work, it remains an area which is significantly lacking in academic research. Literature around the experiences of social workers undertaking pre-birth assessment work is almost entirely missing from research, with only two studies exploring this within the wider context of their study, one in Scotland and one in Australia. This study aims to offer insight into the experiences of social workers in one region of England, and to explore the impact that pre-birth assessment work has on them.

The objectives of my study are as follows:

- To explore social workers' understanding of pre-birth assesments and how these relate to other aspects of children and families' social work.
- To understand the experience of undertaking pre-birth assessments within their role.
- To explore what impact this work has on them, both personally and professionally.
- To establish how they have been supported to complete this work, or how they would like to be supported.

The study is qualitative and will involve a semi-structured interview which should last around an hour. The interviews can take place at a location of your choosing.

In order to take part in this study you need to have had experience as a practicing and qualified social worker (either currently or previously) in the North East of England and had involvement in pre-birth assessment work as part of this role.

You can request the formal participant information sheet by emailing me at c.bleasby@dundee.ac.uk and this will be shared with you before you agree to take part in the study.

Your involvement in the study will be fully anonymised and you will not be able to be identified in any of the information you share.

Section 1 ...

If you are still interested in participating, please complete the following questions.

This information will be stored securely on the University of Dundee network.

1. What is the best email address to contact you?

Enter your answer

2. How many years have you been qualified as a social worker?

- ◯ 0-1 years
- ◯ 1-2 years
- ◯ 2-4 years
- ◯ 4-6 years
- ◯ 6-10 years
- ◯ 10+ years

3. Very briefly, what has your involvement been in pre-birth assessments? Think about how many you have been involved in, and in what capacity.

Enter your answer

4. What type of teams (duty/safeguarding/pre-birth assessment) have you been in when you have had involvement with pre-birth assessment work? And which Local Authorities has this been within?

Enter your answer

Section 2 ...

Thank you for your interest and taking the time to complete this form

Thank you for taking the time to complete this form. Please get in touch via email if there is any other information you would like to know about the study: c.bleasby@dundee.ac.uk

As this research is qualitative in nature and is being completed as part of my fulfillment of the Doctorate of Social Work at the University of Dundee, I am limited in the number of people who I am able to include within the study. In the event that more people are interested within the study that I am able to include, I will need to select participants from those interested. This will be based on involving people with a variety of experiences, so please do not feel disheartened if you are not ultimately selected for the study.

If you are not selected you are still able to keep in touch regarding the outcomes of the study, please answer the following question regarding your preferences for this,

If you would like to keep in touch but are not selected as a participant for the study, I will keep your email address in a password protected folder on the University of Dundee network and only access this to disseminate my findings upon completion.

5. Would you like to be informed of the outcomes of the study?

- ◯ Yes - only if I am included within the study
- ◯ Yes - whether I am included in the study or not
- ◯ No

10.6. Appendix E: List of talking therapy support services

Service	Details
Talking Helps Newcastle	Tel: 0191 2826600 Newcastle upon Tyne, NE1 6ND
North Tyneside Talking Therapies	Tel: 0191 295 2775 Wallsend Health Centre The Green Wallsend Tyne and Wear NE28 7PD
Gateshead Talking Therapies	Tel: 0191 283 2541 The Croft Springwell Road Wrekenton Gateshead Tyne and Wear NE9 7BJ
South Tyneside Lifecycle Primary Care Mental Health	Tel: 0191 283 2937 South Tyneside Lifecycle Primary Care Mental Health Service Cleadon Park Primary Care Centre Prince Edward Road South Shields NE34 8PS
Talking Matters Northumberland	Tel: 0300 303 0700 Unit 4 Telford Court Morpeth Northumberland NE61 2DB
Starfish Health and Wellbeing Teesside	Tel: 01642 672 987 8 Yarm Road Stockton Cleveland TS18 3NA
Insight Healthcare Talking Therapies	Tel: 0300 555 0555 2nd Floor Victoria House 159 Albert Road Middlesbrough Cleveland TS1 2PX
Northallerton IAPT	Tel: 01609 768 890 Thurston Road Gibralter House Northallerton North Yorkshire DL6 2NA

York and Selby IAPT	Tel: 01904 556 840 Huntington House Jockey Lane Huntington York North Yorkshire YO32 9XW
First Step	Tel: 0191 246 6800 2A Tynefield Drive Penrith CA11 8JA

10.7. Appendix F: Interview guide

Interview overview:

- Views on pre-birth assessment and how it fits into children and families social work
- Experiences of undertaking pre-birth assessments and the impact that this has had on you
- What support you have received, how this has helped, and what support might be beneficial.

N. B. This is a guide and not a strict protocol

Background

Can you tell me a bit about your involvement in pre-birth assessment work

What do you see as your role during a pre-birth assessment?

Experiences

How prepared have you felt undertaking these assessments?

How well do you feel able to articulate to families what the assessment is about?

What do you find most difficult?

What do you find more rewarding?

How do you justify the being involved with families before birth to yourself? What do you focus on?

How do you manage emotions?

How have you found working with other professionals?

How would you define a ‘good’ pre-birth assessment?

Impact:

How has doing this work impacted you? Thinking about positive and negative experiences.

What are your thoughts about the impact on the family?

Support

Where do you get support?

What additional support do you think would be helpful?

Is there anything else you want to discuss about pre-birth assessment?

10.8. Appendix G: Email outline of the study

Hi,

My name is Cally Bleasby and I am a Professional Doctorate student at the University of Dundee. I am in the process of completing my thesis, which aims to explore the impact of pre-birth assessment work on social workers. I am currently seeking social workers to take part in my thesis research.

The working title for the research is “The Impact of Pre-birth Assessment Work on Social Workers” and I am planning to conduct one-to-one interviews with social workers to explore their experiences of undertaking pre-birth assessments. During the interview we will also discuss any involvement in any ongoing work with families, including child protection, child in need, court hearings and the removal of infants shortly after birth. The objectives of my study are as follows:

- To explore social workers' understanding of pre-birth assessments and how these relate to other aspects of children and families' social work.
- To understand the experience of undertaking pre-birth assessments within their role.
- To explore what impact this work has on them, both personally and professionally.
- To establish how they have been supported to complete this work, or how they would like to be supported.

Despite evidence that pre-birth assessment work is increasing in social work, it remains an area which is significantly lacking in academic research. Literature around the experiences of social workers undertaking pre-birth assessment work is almost entirely missing from current research, with only two studies exploring this within the wider context of their study, one in Scotland and one in Australia. This study will offer insight into the experiences of social workers undertaking pre-birth assessment work within England.

To be included within the study you need to have experience of undertaking pre-birth assessments as a social worker, this could be in a previous role or in your current role, and be based within the North East of England. Taking part in the study will include an interview which will be with myself and will last approximately an hour. I am planning to undertake interviews in person as I am aware the topic can be emotive, and the interview can be conducted at any setting where you would feel comfortable.

I have attached the participant information sheet to this email and you can contact me at c.bleasby@dundee.ac.uk for any further information you may require, or if you have any questions.

If you are interested in taking part in the research, please could you complete a short form which asks for your contact details and a brief overview of your

involvement in pre-birth assessment work - https://forms.office.com/r/BdqbE5BPHR. Following your completion of the form, I will get in touch via email within two weeks to arrange a suitable time and venue for the interview.

Many thanks,

Cally Bleasby