

Concealment and Denial of Pregnancy

This chapter was updated October 2020

Contents

1. [Introduction](#)
2. [Definition](#)
3. [Implications of a Concealed or Denied Pregnancy](#)
4. [Indicators of Concealed or Denied Pregnancy](#)
5. [Professional response to a Suspicion of Concealed or Denied Pregnancy and Unassisted Birth](#)
6. [Referral to Children's Social Care](#)
7. [Maternal Mental Health](#)
8. [Legal Considerations about Concealment and Denial of Pregnancy](#)
9. [Educational Settings](#)
10. [Health Professionals](#)
11. [Midwives and Midwifery Services](#)
12. [Adult Services](#)
13. [Children's Social Care](#)
14. [Police](#)
15. [Other Agencies \(including the Voluntary Sector\)](#)

[Appendix 1: Concealed Pregnancy and Birth Flowchart: Suspicions Arise that a Pregnancy may be Concealed or Denied](#)

[Appendix 2: Concealed Pregnancy and Unassisted Birth Flowchart](#)

[Appendix 3: Concealed Pregnancy and Birth Flowchart: Possibility of a Future Pregnancy when there has been a known Concealed or Denial of Pregnancy](#)

[Appendix 4 Think Family - Identifying the Needs of Children, Unborn Children and Families](#)

1. Introduction

The concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare of the unborn baby and the expectant mother. While concealment and denial, by their very nature, limit the scope of professional help, better outcomes can be achieved by coordinating an effective inter-agency approach. Good information sharing and consultation between agencies underpins this procedure.

Concealment and denial of pregnancy may be suspected at any stage during pregnancy, in labour or following delivery. The birth may be unassisted (no midwife) whereby there might be additional risks to the baby and mother's welfare and long-term outcomes.

See [Appendix 1: Concealed Pregnancy and Birth Flowchart: Suspicions Arise that a Pregnancy may be Concealed or Denied.](#)

See [Appendix 2: Concealed Pregnancy and Unassisted Birth Flowchart](#)

It is particularly important to take into account any history of concealed pregnancies and this will also apply to future pregnancies where there has been a previous concealed pregnancy. The concealment or denial of a pregnancy should trigger professional curiosity and be considered a potential risk factor for the unborn baby's health and welfare at birth

(see [Appendix 3: Concealed Pregnancy and Birth Flowchart: Possibility of a Future Pregnancy when there has been a known Concealed or Denial of Pregnancy](#)).

2. Definition

For the purposes of this procedure reference to "expectant mother" means a female of childbearing capacity (including under 18's). A pregnancy will not usually be considered as concealed or denied for the purpose of this procedure until it is estimated or confirmed to be at least 24 weeks; this is the point of viability.

However by the very nature of concealment or denial it is not always possible to be certain of the stage the pregnancy is at and professionals with established working relationships with women or young people may become suspicious that she is pregnant based on their observations from an early stage of a possible pregnancy. For this reason, responses to

support women to disclose and access help and support including health care will require some professional judgement.

A concealed pregnancy is when:

- An expectant woman knows she is pregnant but does not tell any professional;
or
- An expectant woman tells another professional but conceals the fact that she is not accessing antenatal care;
or
- An expectant woman tells another person/s and they conceal the fact from health or social care agencies.

A denied pregnancy is when:

- an expectant mother is unaware of, or unable to accept, the existence of her pregnancy. Physical changes to the body may not be immediately present or may be misinterpreted. Although the expectant mother may be at some level intellectually be aware of the pregnancy she may continue to believe, feel and behave as though she was not.

In some cases, a woman may be unaware that she is pregnant until late in the pregnancy due to a learning disability or other vulnerability.

Concealment may occur because of stigma, shame or fear because the pregnancy may be the result of incest, sexual abuse, rape or as part of a violent relationship.

3. Implications of a Concealed or Denied Pregnancy

It may be difficult to establish with certainty whether the pregnancy is concealed or denied.

The implications of concealment and denial of pregnancy are wide-ranging.

- Concealment of a pregnancy can lead to a fatal outcome (for both mother and/or baby), regardless of the mother's intention;
- Concealment may indicate uncertainty towards the pregnancy, immature coping styles and a tendency to dissociate, all of which are likely to have a significant impact on bonding and parenting capacity;
- Lack of antenatal care can mean that any potential risks to mother and baby may not be detected. It may also lead to inappropriate advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy;

- The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected and underlying medical conditions and obstetric problems will not be revealed;
- An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery;
- Lack of maternal willingness/ability to consider the baby's health needs, or lack of emotional attachment to the baby following birth;
- There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community; there may be risks to both mother and baby if there is a fear of disclosing the paternity of the baby for example where the baby has been conceived as the result of sexual abuse or where the father is not the woman's partner, also risk to the mother if there is Domestic Abuse in the relationship
- There may not have been opportunities to plan for the baby and to adjust emotionally to the responsibilities of parenting including establishing support networks. This may have a significant impact on bonding and parenting capacity and can present risk to the baby at birth and require a multi-agency response to coordinate both practical and emotional support for the mother to build a supportive network.
- A concealed pregnancy and an unassisted delivery can be shocking and traumatic for the wider family, notably grandparents. It would be helpful for the family functioning if these feelings are acknowledged, given that family members may play a key role in supporting the mother and baby
-

4. Indicators of a Concealed or Denied Pregnancy

- Previous concealed pregnancy is an important indicator in predicting risk of a future pregnancy being concealed;
- Previous termination, thoughts of termination and/or unwanted pregnancy;
- Loss of a previous child (i.e. adoption, removal under Care Proceedings);
- General fear of being separated from the baby.

Substance-misusing mothers or mothers who have had previous statutory intervention may avoid seeking help during pregnancy if they fear that this disclosure will inevitably lead to statutory agencies removing their baby. It may be important to consider the role of collusion within the family.

5. Professional response to Suspicion of Concealed or Denied Pregnancy and Unassisted Birth

See also: [Appendix 1: Concealed Pregnancy and Birth Flowchart: Suspicions Arise that a Pregnancy may be Concealed or Denied.](#)

[Appendix 2: Concealed Pregnancy and Unassisted Birth Flowchart](#)

See also [Section 10: Midwives and Midwifery Services](#)

Although 24 weeks gestation is the time frame following which the pregnancy is considered “viable”, a referral to children’s social care may be required at any point in a pregnancy if as part of working with the woman a professional becomes suspicious that a pregnancy is being concealed or denied and that efforts to encourage engagement with health services have failed and wider vulnerabilities suggest support needs require a multi-agency assessment.

1. Where any professional believes the expectant mother to be concealing or denying a pregnancy then as early as possible, they should sensitively enquire of the expectant mother if she might be pregnant. It may be appropriate to identify a professional who has a good working relationship with the woman to assist with the discussion and to provide reassurance to the woman to encourage contact with her GP and to take up offers of support for wider vulnerabilities.
2. An agency may find it useful to consult with the safeguarding midwife to seek support to assist in engaging the woman with midwifery services and to confirm the pregnancy (See Midwifery Section below)
3. If a pregnancy is confirmed by the woman then she should be strongly encouraged to go to her GP to access antenatal care. The GP practice will help an expectant mother register with Midwifery Services for ultrasound scanning and advice about pregnancy and birth.
4. Even if the mother discloses her pregnancy and engages with health services, consideration of any additional support needs should always be considered as part of the judgement made by the GP or Midwife or other involved professionals. This will include consideration of referrals for services from Early Help, Childrens social care and Adult services in line with [pre-birth procedure/pathways.](#)

4.1 This will take into account the reason for late presentation including the reason why the pregnancy was initially denied or concealed and any context that the woman has provided together with wider vulnerabilities and risk factors.

Risk Factors

- *Children under the age of 13 (a referral is required in all circumstances where the child is under 13 and pregnant);*
- *Children between the ages of 13 and 16 years;*
- *Abuse of drugs/alcohol by the pregnant woman (or partner);*
- *Evidence of Domestic Abuse including Coercion and Control;*
- *Women who may be involved in sex work;*
- *Women who may be Victim of Modern Slavery;*
- *Women where Learning Disabilities/Physical Disabilities may indicate additional support is required to parenting*

Where maternal consent cannot be obtained to make a referral for support in these circumstances the concealment or denial of pregnancy will be considered an additional risk factor as set out in in 6.2 below.

Any professional who has concerns that a woman is concealing or denying pregnancy should make contact with Children's Social Care for advice and information sharing so that there is consideration of any multiagency action that is required including the need for a referral to be made for a social work assessment. The reasons why a referral may be required are detailed below.

Following this contact: actions and any agreed time frames for actions to be completed including time of next discussion should be carefully documented and shared between the professional and social worker

In cases where mother arrives at the hospital in labour, or mother and baby are admitted following an unassisted delivery, where medical/ante-natal care has not been accessed then the baby should not be discharged from hospital until multi-agency Strategy Discussions have been held, immediate risks assessed and a multi-agency Discharge Plan put in place.

6. Referral to Children's Social Care

A Referral to Children's social care must always be made in the following circumstances: -

- If the woman discloses a concealed or denied her pregnancy and refuses to take up medical care during her pregnancy once disclosed
- If an unrecorded pregnancy is confirmed at the time of birth for example by means of a presentation to hospital in labour or after an unassisted birth and is judged to be 24 weeks gestation
- Where despite professional engagement, a pregnancy continues to be denied and the professional has reasonable grounds to suspect the pregnancy is concealed or denied
- Where despite engagement with services there are vulnerabilities and risk factors that warrant referral to discuss pre-birth planning as per the pre-birth pathway

The expectant mother should be informed that the referral has been made, the only exception being if there are significant concerns for her safety or that of the unborn baby.

Note:- The absence of consent should not prevent a referral being made on the basis that a professional judgement has led to concerns that a pregnancy is being concealed or denied - see [Information Sharing Procedure](#).

Click on the links below for the Referrals Procedure:

[Leicester City](#)

[Leicestershire](#)

[Rutland](#)

All agencies should ensure that actions and information about the concealment is clearly recorded to ensure its significance is not lost and to ensure that potential future risks can be fully assessed and managed.

If the mother is 18 and over and has a Learning Disability or Mental Ill Health problems a referral to Adult Social Care should be considered. If the mother has care and support needs and is/has suffered significant harm, then a [Safeguarding Adults Referral](#) should be made.

7. Maternal Mental Health

In cases where there has been concealment and denial of pregnancy, especially where there has been unassisted delivery, a referral for a full mental health assessment should be considered.

In addition, the baby should not be discharged until a multi-agency [Strategy Meeting](#) has been held and relevant assessments undertaken. A discharge summary from maternity services to the relevant GP must record if a pregnancy was concealed or denied or booked late (beyond 24 weeks)

8. Legal Considerations about Concealment and Denial of Pregnancy

United Kingdom law does not legislate for the rights of unborn children and therefore a foetus is not a legal entity and has no separate rights from its mother. This should not prevent plans for the protection of the baby being made and put into place to safeguard the baby from harm both during pregnancy and after the birth.

In certain instances, legal action may be available to protect the health of an expectant mother, and therefore the unborn baby, where there is a concern about the ability to make an informed decision about proposed medical treatment, including obstetric treatment. The Mental Capacity Act 2005 states that the person must be assumed to have capacity unless it is proven that she does not. A person is not to be treated as unable to make a decision because they make an unwise decision. It may be that an expectant mother denying her pregnancy is suffering from a mental illness and this is considered an impairment of mind or brain, as stated in the act, but in most cases of concealed and denied pregnancy this is unlikely to be the case.

Information on the Mental Capacity Act 2005 can be found in the [Safeguarding Adults Procedures – Mental Capacity](#).

There are no legal means for a Local Authority to assume [Parental Responsibility \(PR\)](#) over an unborn baby. Where the mother is a child and subject to a legal order, this does not confer any rights over her unborn baby or give the local authority any power to override the wishes of an expectant mother in relation to medical help. Child protection planning and planning within the Public Law Outline

9. Educational Settings

In many instances staff in educational settings may be the professionals who know a young expectant mother best. There are several signs to look out for that may give rise to suspicion of concealed pregnancy:

- Increased weight or attempts to lose weight;
- Wearing uncharacteristically baggy clothing;
- Concerns expressed by friends;
- Repeated rumours around school or college;
- Uncharacteristically withdrawn or moody behaviour;
- Signs consistent with morning sickness.

Staff working in educational settings should try to encourage the pupil to discuss her situation, through normal pastoral support systems, as they would any other sensitive issue. Every effort should be made by the professional suspecting a pregnancy to encourage the young expectant mother to obtain medical advice. However, where they still face denial or non-engagement further action should be taken. It may be appropriate to involve the assistance of the Designated Safeguarding Lead and School Nurse in addressing these concerns.

Consideration should be given to the balance of need to preserve confidentiality and the potential concern for the unborn baby and the mother's health and well-being. Where there is a suspicion that a pregnancy is being concealed it is necessary to share this information with other agencies, irrespective of whether consent to disclose can be obtained.

Education staff may often feel the matter can be resolved through discussion with the parent of the young expectant mother. However, this will need to be a matter of professional judgement and will clearly depend on individual circumstances including the relationship with parents.

It may be felt that the young expectant mother will not admit to her pregnancy because she has genuine fear about her parent's reaction, or there may be other aspects about the home circumstances or factors that give rise to concern. If this is the case or if there is a lack of progress in resolving the matter in any circumstances or escalating concerns that a young expectant mother may be concealing or denying she is pregnant there must be a referral to Children's Social Care and advice and information sharing. Where there are significant concerns regarding the girl's family background, home circumstances/factors

such as a history of abuse or neglect, [Referrals to Children's Social Care](#) should be made without speaking to the parent's first if there is reasonable cause to believe that seeking consent to making a referral could increase the risks for the mother's welfare or that of the unborn baby.

If education staff do engage with parents, they need to consider the possibility of the parent's collusion with concealment. Whatever action is taken, whether informing the parents or involving another agency, the young expectant mother should be appropriately informed, unless there is a genuine concern that in so doing, she may attempt to harm herself or the unborn baby.

As with any referral to Children's Social Care, the parents and young expectant mother should be informed, unless in doing so there is reasonable cause to believe this could increase the risks for her welfare or that of her unborn baby.

10. Health Professionals

The health professionals who may be involved include:

- Health Visitors;
- School nurses;
- General Practitioners (GP) and Practice nurses;
- Midwives and Obstetricians/Gynaecologists;
- Emergency Department staff;
- Mental Health Nurses;
- Drug and alcohol workers;
- Learning Disability workers;
- Psychologists and Psychiatrists;
- CAMHS.

(This is not an exhaustive list).

All health professionals should give consideration to the need to make or initiate a referral for a mental health assessment at any stage of concern regarding a suspected (or proven) concealed or denied pregnancy.

Emergency Department (ED) staff or those in Radiology departments need to routinely ask women of childbearing age whether they might be pregnant.

If suspicions are raised that a pregnancy may be being concealed or a pregnancy is confirmed Maternity Services should be contacted.

Where the pregnancy is confirmed the patient should be transferred to the maternity admissions unit (MAU) where she can be fully reviewed by the maternity team. Should the patient refuse transfer to maternity a Midwife will attend the Emergency Department to ensure an appointment for a scan and community midwife is made prior to discharge. This must be recorded in the discharge notes and an appropriate note made to the referring GP for follow up with the patient.

Primary Care: Where a GP or Practice Nurse has significant reason to believe an expectant mother is pregnant, further action needs to be taken in line with these procedures. This should include a documented discussion with the Midwife, Health Visitor or School Nurse, (as appropriate), It may be helpful to discuss the concerns with the Designated Doctor or Nurse Safeguarding Children

11. Midwives and Midwifery Services

If contact is made with midwifery services by an agency seeking support for a woman where there is concern that a pregnancy is concealed or denied the safeguarding midwifery service will consider what support can be provided to encourage the woman to confirm her pregnancy and take up antenatal care. This may include planning a joint visit with another professional

If the woman presents late (beyond 24 weeks) for Midwifery and Obstetric Services in the antenatal period, a thorough social and medical history needs to be taken. There may be many reasons why the woman has concealed the pregnancy and the midwife needs to ensure the possibility of domestic violence and mental health issues are explored.

Note:- The absence of consent should not prevent a referral being made on the basis that a professional judgement has led to concerns that a pregnancy is being concealed or denied - see [Information Sharing Procedure](#). Women aged 18 or under should be referred to the specialist midwife for teenagers.

The woman may be referred to a Consultant Obstetrician if deemed necessary. An urgent scan must also be booked to determine the gestation of the baby.

If an expectant mother arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, then an urgent referral must be made to Children's Social Care, If this is in an evening, weekend or over a public holiday then Children's Services can still be contacted following the links in Section 6

If the baby has been harmed in any way or there is a suspicion of harm, or the baby is abandoned by the mother, then the Police must be informed immediately, and a referral made to Children's Social Care.

Midwives should ensure information regarding the concealed pregnancy is placed on the baby's, as well as the mother's health records. Following an unassisted delivery or a concealed/denied pregnancy midwives need to be alert to the level of engagement shown by the mother, and her partner/extended family if observed, and of receptiveness to future contact with health professionals. In addition, midwives must be observant of the level of attachment behaviour demonstrated in the early postpartum period.

In cases where there has been concealment and denial of pregnancy, especially where there has been unassisted delivery, a referral for a full mental health assessment should be considered whilst the mother is an inpatient, if a referral is not made the rationale must be carefully recorded in the notes . In addition the baby should not be discharged until a multi-agency **Strategy Discussions** has been held and relevant assessments undertaken. A discharge summary from Maternity Services to primary care must report if a pregnancy was concealed or denied or booked late (beyond 24 weeks).

12. Adult Services

There may be occasions during the course of their work when staff working with adults come across a concealed or denied pregnancy. In these circumstances a discussion must take place between the staff member and their line manager who will agree what action is required. In most cases the Safeguarding Standards Manager for Adult Social Care should be advised and a **[Referrals to Children's Social Care](#)** made.

13. Children's Social Care

- 13.1 When Children's Social Care are contacted for advice or information sharing based on professional concern that a pregnancy is being concealed or denied a check will always be carried out of Children's Social Care records and any history of intervention so that any necessary multiagency action can be agreed.
- 13.2 Any advice including when an agency have been asked to make a referral to Children's Social Care must be recorded clearly and any decision to take no further action must have a clear rationale for taking this action recorded.
- 13.3 Where a referral is made as set out in section 6 above and the referral gives reasonable cause to suspect that a pregnancy is concealed or denied Children's Social Care will convene a multi-agency strategy meeting /discussion (see [Strategy Discussions Procedure](#)), on the basis of the likelihood of harm posed to the unborn baby. .
- 13.4 The strategy meeting will consider all the information available and what further action is required to determine the side by side of risk or additional support needs of the baby including the needs of the mother, this may include the need to undertake [Section 47](#) enquiries or to undertake a multi-agency assessment under [Section 17](#) or to make referrals to other referrals to agencies available to support the mother.
- 13.5 Where an expectant mother under age 18 is suspected of being pregnant then professionals must also consider that she is also a **Child in Need**
- 13.6 If she is less than 16 years, then a criminal offence may have been committed and needs to be investigated by the police.
- 13.7 Consideration must also be given, at the earliest opportunity, to refer a young person to CAMHS
- 13.8 If the mother is 18 and over and has a Learning Disability or Mental ill Health problems a referral to Adult Social Care should be considered. If the mother has care and support needs and is/has suffered significant harm, then a [Safeguarding Adults Referral](#) should be made.

13.9 The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the unborn baby or new-born baby. A multi-agency assessment may need to include in some circumstances a mental health assessment.

Regardless of the age of the expectant mother where there are additional concerns (to the suspected concealed or denied pregnancy) such as a lack of engagement, possibility of sexual abuse, or substance misuse, then **Section 47 Enquiries** should be considered and a Pre-Birth Conference (see [Initial Child Protection Conferences Procedure, Pre-Birth Conferences](#)).

Where a baby has been harmed, has died or has been abandoned then a **Section 47** investigation must be completed in collaboration with the Police. If the baby has died, see the [Responding to Child Death Procedure](#).

Any referral received by Children's Social Care's in relation to a baby born following a concealed or denied pregnancy, or where a mother and baby have attended hospital following an unassisted delivery, then steps must be taken to prevent the baby being discharged from hospital until a multi-agency strategy meeting has been held and a plan for discharge agreed. This would ordinarily be done by voluntary agreement with the expectant mother, although clearly circumstances may arise when it may be appropriate to seek an **Emergency Protection Order**. Alternatively, the assistance of the Police may be sought to prevent the baby from being removed from the hospital.

In undertaking an assessment, the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the baby. These factors along with the other elements of the **Assessment Framework** are key in determining risk. See also [Assessment](#)

Accessing Psychological/ Psychiatric Services in cases of concealment and denial of pregnancy may be appropriate. Consideration should be given to referring an expectant mother for assessment, in these circumstances. For more information see [Appendix 4 Think Family - Identifying the Needs of Children, Unborn Children and Families](#)

14. Police

The Police must be notified of any child protection concerns received by Children's Social Care where concealment or denial of pregnancy is an issue. A police representative will be invited to attend a multi-agency strategy meeting to consider the circumstances and decide whether a joint **Section 47** investigation should be carried out.

Factors to consider will be the age of the expectant mother whom is suspected or known to be pregnant, and the circumstances in which she is living, to consider whether she is a victim or potential victim of a criminal offence. In all cases where a child has been harmed, been abandoned or died it will be incumbent on police and Children's Social Care to work together to investigate the circumstances. Where it is suspected that neonaticide or infanticide has occurred then the Police will be the primary investigating agency.

15. Other Agencies (including the Voluntary Sector)

All professionals or volunteers in statutory or voluntary agencies who provide Services to women of child bearing age should be aware of the issue of concealed or denied pregnancy and follow this procedure when a suspicion arises.

All referrals will be made to the Children's Social Care initially as a referral on an unborn baby (see Section 6)

Where the expectant mother is under 18 years of age she will be considered as a **Child in Need** and assessed accordingly.

Appendices

Appendix 1: Concealed Pregnancy and Birth Flowchart: Suspicions arise that a pregnancy may be concealed or denied

Practitioner has concerns that a woman is pregnant and is concealing or

Appropriate Practitioner sensitively asks woman if they are pregnant (relationship may need to be built first)

Woman is spoken to on her own and continues to deny pregnancy.
Practitioner remains concerned that pregnancy is being denied or

Encourage woman to seek appropriate antenatal care and follow up as

Undertake antenatal assessment and consider risk indicators (Section 5 Procedure)

Discuss with Designated Safeguarding Lead or Manager

This will include consideration of a referral to Childrens Social Care, where a decision will be made regarding the appropriate level of intervention i.e . Child Protection, Child and Family Assessment, Early Help.in line with [pre-birth procedure/pathways](#)

Appendix 2: Concealed Pregnancy and Unassisted Birth Flowchart

An expectant mother arrives at the hospital in labour, or mother and baby are admitted following an unassisted delivery, where medical/ante-natal care has not been accessed.

If the baby has been harmed in any way or there is a suspicion of harm or the baby is abandoned, then the Police must be informed immediately

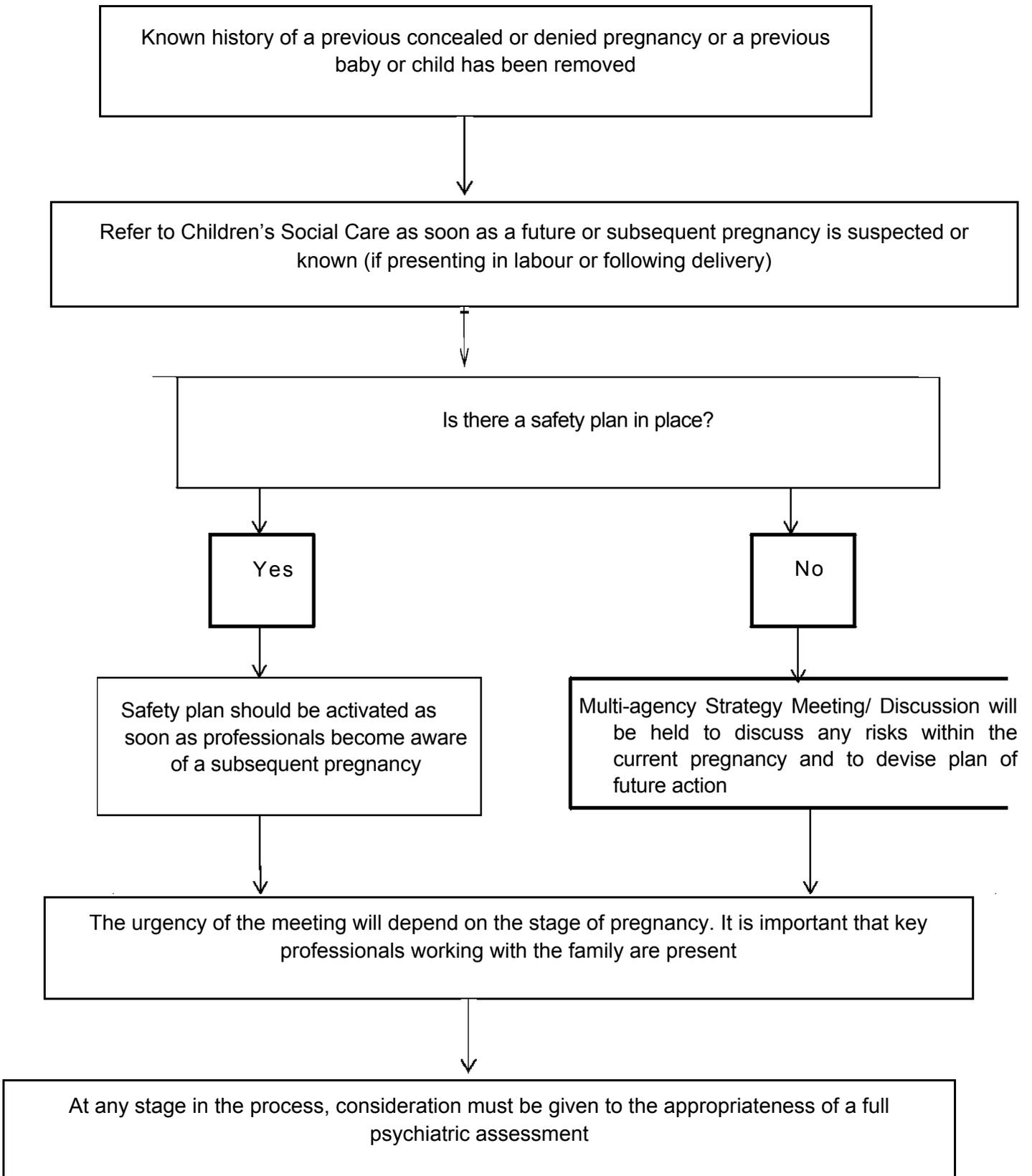
An urgent referral must be made to Children's Social Care

An urgent referral should be made to Adult Social Care if the mother has care and support needs and significant harm is suspected

A referral for a full mental health assessment should be considered whilst the mother is an inpatient

The baby should not be discharged from hospital until multi-agency [Strategy Discussions](#) have been held, immediate risks assessed and a multi-agency Discharge Plan put in place.

Appendix 3: Concealed Pregnancy and Birth Flowchart: Possibility of a Future Pregnancy when there has been a known Concealed or Denial of Pregnancy



Appendix 4 Think Family - Identifying the Needs of Children, Unborn Children and Families Families with Complex and Multiple Needs

Agencies find it difficult to provide a co-ordinated and adequate response to the minority of families who face multiple and complex problems and needs. Local professionals have consistently identified the need to find more effective ways of working across adults and children's services. This is echoed at government level by the review "Think Family: improving the life chances of families at risk". This identifies that greater priority needs to be given to ensuring there are joint and collaborative working practices within and across agencies to respond to the increasing separation between service areas and increasing specialisms within these areas. Without this, it will be very difficult to effectively protect children, support parents and carers. Research has identified that families want services that are multi-disciplinary and which do not withdraw when the crisis is over but continue to prevent or reduce the circumstances that can result in further crisis. The most effective multi-disciplinary work retains a family focus, builds on the strengths of family members and provides support tailored to need.

Diversity and Child Protection

This aims to strengthen multi-agency working with families where one or more adults have been identified with issues which potentially put children at greater risk. These are children who:

- Have a parent/ carer with a history of domestic violence/other known violence;
- Have a parent/carer who has a psychosis;
- Have a parent/carer with a significant personality disorder;
- Have a parent/carer who misuses substances(drugs or alcohol);
- Have a parent/carer with combinations of the above such as dual diagnosis of mental illness combined with drug and alcohol abuse;
- Become targets for parental or carer hostility, aggression or rejection;
- Feature within parental/carer delusions;
- Are seriously emotionally and/or physically neglected as a result of parental or carer illness/functioning;
- Are routinely used to meet a parent/carers own needs including fabricating or inducing illness in their children;
- Have a parent/carer who has a partner or ex-partner who fits any of the above categories.

It is important to avoid stereotyping so that individuals still feel able to approach agencies, including Social Care Services, for help, support and protection and opportunities for early intervention are not lost.

However, serious case reviews have consistently shown that the issues identified above individually or often in combination can significantly impact on the functioning of the adults and their families and increase the range and level of risks experienced. They may impact on the ability to parent and/or protect their children or unborn child. In many cases the parent/carer will face simultaneous multiple difficulties both economic and/or social. Adults in these families may themselves be adults in need of safeguarding. Consideration also needs to be given to the needs of disabled children and their families). In addition, there may be increased risks to disabled children where there is domestic violence and some disabled children may be violent toward parents or carers.

End