

Supporting Today, Preparing Tomorrow's Parents

Understanding and Improving Early Support for Expectant Parents with Intellectual Disabilities.

Annick Zijlstra - Kroek

THESIS

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Expect Jeugd
Expertisecentrum
Partners voor Jeugd

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Understanding and Improving Early Support for Expectant Parents with Intellectual Disabilities

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Table of contents

Chapter 1 Samenvatting **6**

Chapter 2 General introduction **16**

Chapter 3 Expectant parents with intellectual disabilities in child protection: Risk factors for child safety **25**

Chapter 4 Exploring profiles of families of parents with intellectual disabilities in child protection: A cluster analysis **56**

Chapter 5 The first 1001 days: A scoping review of parenting interventions strengthening good enough parenting in parents with intellectual disabilities **95**

Chapter 6 An International Overview of Child Protection Services to Protect Unborn Children from Significant Harm **131**

Chapter 7 An intervention for expectant parents with intellectual disabilities with child's safety concerns: A feasibility study **166**

Chapter 8 The Impact of an Early Preventive Intervention on Child Safety: Evidence from the Safe Start Program **192**

Chapter 9 General discussion **227**

Summary **241**

References **250**

Dankwoord **268**



Chapter 1

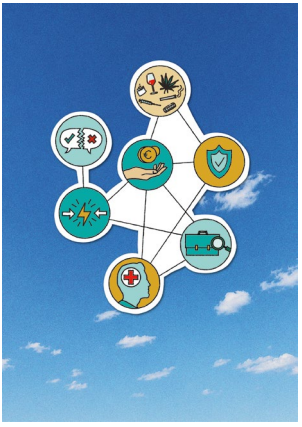
Samenvatting

Vandaag ondersteunen voor het ouderschap van morgen: Inzicht krijgen in het verbeteren van vroege ondersteuning voor aanstaande ouders met een verstandelijke beperking.

Historisch gezien werden ouders met een verstandelijke beperking lange tijd omgeven door stigma, uitsluiting en de veronderstelling dat zij niet in staat zouden zijn hun kinderen op te voeden (Aunos et al., 2020; Beltran-Arreche et al., 2025). Hoewel dergelijke opvattingen nog steeds bestaan, is in de afgelopen decennia een duidelijke verschuiving zichtbaar naar erkenning van mensen met een verstandelijke beperking als volwaardige burgers met gelijke rechten. Daaronder valt het recht op gezinsvorming en ouderschap, maar ook het recht op adequate ondersteuning om hun ouderschapsrol te kunnen vervullen, zoals vastgelegd in het VN-Verdrag inzake de Rechten van Personen met een Handicap (2006). Tegelijkertijd laat recent onderzoek zien dat het ouderschap bij ouders met een verstandelijke beperking vaak gepaard gaat met uitdagingen en verhoogde risico's op onveilige opvoedsituaties (e.g., Aunos et al., 2008; Beltran-Arreche et al., 2025; Meppelder et al., 2015; McConnell et al., 2021; Feldman & Aunos, 2020). Deze uitdagingen en

onveilige situaties zijn niet één-op-één te relateren aan de verstandelijke beperking zelf, maar komen vaak voort uit een complex samenspel van individuele, relationele en contextuele factoren, zoals psychische problematiek, ingrijpende jeugdervaringen, armoede en beperkte toegang tot passende hulp (Feldman & Aunos, 2020). Deze risico's kunnen zich reeds tijdens de zwangerschap manifesteren of toenemen, terwijl steunbronnen voor ouders met een verstandelijke beperking niet altijd toereikend of beschikbaar zijn om deze cruciale transitiefase naar het ouderschap te ondersteunen (Lawler et al., 2015).

Om passende ondersteuning te bieden, die zowel recht doet aan het ouderschapsrecht van ouders met een verstandelijke beperking als aan de veiligheid en bescherming van het kind, is verdiepend inzicht nodig in de risicofactoren die deze ouders ervaren tijdens de zwangerschap in samenhang met de veiligheid van het kind, in de bestaande vrijwillige en gedwongen interventies voor deze doelgroep en in de effectiviteit van een nieuwe preventieve interventie voor deze doelgroep. Dit proefschrift onderzoekt deze drie samenhangende vraagstukken.



Het eerste vraagstuk betreft de aard, cumulatie en betekenis van risicofactoren tijdens de zwangerschap in relatie tot de veiligheid van het kind. **Hoofdstuk 3** levert hieraan een belangrijke empirische bijdrage doordat het systematisch in kaart brengt welke risicofactoren aanwezig zijn bij aanstaande ouders met een verstandelijke beperking die reeds vóór de geboorte een kinderbeschermingsmaatregel opgelegd hebben gekregen en

waarbij dus de veiligheid van het nog ongeboren kind in het geding is. De resultaten van dit dossieronderzoek laten zien dat aanstaande ouders met een verstandelijke beperking vaak te maken hebben met een opeenstapeling van risicofactoren over verschillende levensdomeinen. Specifiek blijkt dat met name risicofactoren binnen het kind-, gezinsfunctionerenen hulpverleningsdomein het sterkst samenhangen met de veiligheid van het kind na de geboorte. Deze resultaten nuanceren het vaak nog heersende idee dat de verstandelijke beperking op zichzelf verklarend is voor onveilige opvoedsituaties, en onderstrepen het belang van een ecologische benadering, waarbij risico's in samenhang worden gezien.



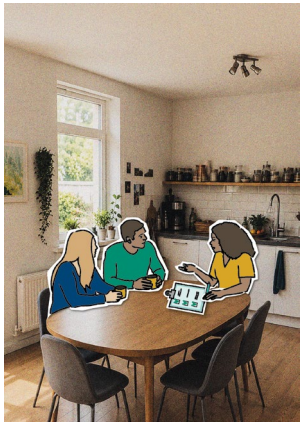
Voortbouwend op deze bevindingen wordt in **Hoofdstuk 4** een studie beschreven waarin werd onderzocht of binnen de populatie van aanstaande ouders met een verstandelijke beperking die reeds vóór de geboorte een kinderbeschermingsmaatregel opgelegd hebben gekregen, risicoprofielen geïdentificeerd konden worden. Door middel van een clusteranalyse werden drie profielen onderscheiden: 1) gezinnen waarin beide ouders een verstandelijke beperking hebben; 2) alleenstaande moeders met een beperkt sociaal netwerk; en 3) gezinnen met meervoudige en complexe problematiek. Deze indeling maakt zichtbaar dat de populatie van ouders met een verstandelijke beperking in de kinderbescherming heterogeen is en dat verschillende combinaties van risicofactoren samenhangen met verschillende kinderbeschermingstrajecten. Hoewel de kans op een uithuisplaatsing binnen zes maanden na geboorte vergelijkbaar bleek tussen de clusters, kwam de overgang

van een ondertoezichtstellingsmaatregel naar een voogdijmaatregel minder vaak voor bij gezinnen waarin beiden ouders een verstandelijke beperking hebben (cluster 1) dan bij de andere clusters. De resultaten van dit hoofdstuk leveren er dus eerste aanwijzingen voor dat differentiatie binnen de doelgroep van aanstaande ouders in de jeugdbescherming relevant is voor besluitvorming en de toeleiding naar hulp.

Gezamenlijk laten Hoofdstuk 3 en Hoofdstuk 4 zien dat risicofactoren tijdens de zwangerschap niet los gezien kunnen worden van de bredere leefcontext van ouders. Het is de opeenstapeling van risicofactoren die gepaard gaan met het hebben van een verstandelijke beperking, en niet de verstandelijke beperking op zichzelf, die bepalend blijkt te zijn voor de veiligheid van het kind, en de toeleiding en besluitvorming binnen kinderbeschermingsmaatregelen. Deze inzichten maken ook duidelijk dat de ondersteuning niet generiek kan zijn voor aanstaande ouders met een verstandelijke beperking, maar moet aansluiten bij verschillende risicoprofielen en gezinscontexten. Daarmee vormen deze hoofdstukken het vertrekpunt voor het tweede vraagstuk, waarin de vraag centraal staat in hoeverre het bestaande interventieaanbod daadwerkelijk aansluit bij deze uiteenlopende ondersteuningsbehoeften.

Om te begrijpen hoe ondersteuning beter kan aansluiten bij de uiteenlopende risicoprofielen van aanstaande ouders met een verstandelijke beperking, is het noodzakelijk te onderzoeken welke interventies daadwerkelijk effectief zijn gebleken voor deze doelgroep. **Hoofdstuk 5** richt zich op deze vraag door bestaande preventieve vrijwillige interventies voor ouders met een verstandelijke beperking die een opeenstapeling van meerdere en complexe problemen ervaren systematisch in kaart te brengen en kritisch te evalueren. De studie beschreven in dit hoofdstuk, laat zien dat het huidige interventieaanbod beperkt is: er worden

internationaal slechts zes preventieve interventies gevonden voor ouders met een verstandelijke beperking die zijn gericht op het versterken van de veertien condities van goed genoeg ouderschap (Zijlstra et al., 2012) in de eerste 1000 dagen van het kind. Daarbij werden in de meeste interventies niet de zeven volgende effectieve werkzame elementen geïntegreerd voor adequate en effectieve ondersteuning aan ouders met een verstandelijke beperking:



1. aandacht voor de context en de meerdere en complexe problemen die deze ouders vaak ervaren;
2. vroegtijdig interveniëren, bij voorkeur al tijdens de zwangerschap;
3. de professional heeft een ondersteunende en afgestemde professionele grondhouding;
4. de professional heeft kennis van de rechten van ouders met een verstandelijke beperking en rechten van het kind;
5. de interventie maakt gebruik van gedragsgerichte leermethodieken, zoals voordoen, belonen en taakanalyse;
6. de interventie is in de thuissituatie, langdurig en intensief waar nodig;
7. de interventie is in partnerschap met het gezin en het sociale netwerk.

De kwaliteit van de onderzoeken naar de effectiviteit van deze zes interventies is matig. Toch tonen de resultaten van deze effectiviteitsonderzoeken aan dat deze interventies positieve en maatschappelijk relevante effecten kunnen hebben voor de opvoedvaardigheden en het

welzijn van het kind. Hiermee benadrukt Hoofdstuk 5 zowel dat er aanzienlijk ruimte is voor het ontwikkelen van meer omvattende en systematisch geëvalueerde preventieve interventies, als het belang van tijdige, vrijwillige en contextueel afgestemde ondersteuning die ouders met een verstandelijke beperking versterkt, vóórdat er sprake is van een crisis.



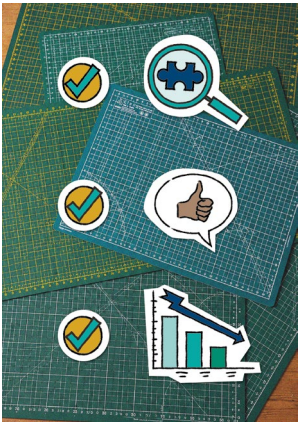
Aanvullend op Hoofdstuk 5, legt **Hoofdstuk 6** de nadruk op het ondersteunen van aanstaande ouders middels interventies in het kinderbeschermingskader. Het beschrijft een studie waarin werd onderzocht of en hoe kinderbeschermingsmaatregelen, al uitgesproken tijdens de zwangerschap, wettelijk mogelijk zijn in twaalf westerse landen, en vergelijkt deze situatie met de Nederlandse praktijk. Uit deze internationaal rechtsvergelijkende studie komt naar voren dat in de meeste landen kinderbeschermingsmaatregelen vóór de geboorte niet bestaan en de focus ligt op preventieve vrijwillige interventies. Naast Nederland zijn er twee landen waar ze wel bestaan met een expliciete wettelijke basis. Echter, in deze twee landen worden kinderbeschermingsmaatregelen vóór de geboorte zeer terughoudend ingezet, slechts enkele keren sinds het bestaan ervan. Nederland vormt hierop een uitzondering: in Nederland wordt enkele honderd keren per jaar een kinderbeschermings-maatregel vóór de geboorte verzocht en uitgesproken, terwijl hier juist een expliciete wettelijke basis ontbreekt. Op basis van de inzichten die zijn opgedaan in deze rechtsvergelijking, worden vier aanbevelingen gedaan voor de Nederlandse beleid en praktijk: 1) verbeter de toegankelijkheid en kwaliteit van vrijwillige ondersteuning; 2) waar-

borg dat vrij-willige ondersteuning daadwerkelijk vrijwillig is; 3) creëer een expliciete wettelijke basis voor kinderbeschermingsmaatregelen vóór de geboorte; 4) maak vrijwillig en gedwongen interveniëren mogelijk vóór de levensvatbaarheidsgrens van 24 weken. Dit hoofdstuk biedt daarmee inzicht in internationale verschillen en levert concrete aanknopingspunten om de Nederlandse praktijk te verbeteren, met als doel interventies beter af te stemmen op de ondersteuningsbehoeften van ouders en de veiligheid van het nog ongeboren kind.

De bevindingen uit Hoofdstuk 5 en 6 laten zien dat het bestaande interventieaanbod nog beperkt en gefragmenteerd is, maar dat gerichte, tijdige en contextuele ondersteuning veelbelovend is. Door de analyse van zowel vrijwillige preventieve als gedwongen interventies te combineren, levert dit deel van het proefschrift belangrijke inzichten voor beleid én praktijk. Daarmee vormt het ook de brug naar het derde vraagstuk: de evaluatie van een nieuwe preventieve interventie voor deze doelgroep.

Waar in de eerste twee vraagstukken primair de analyse van risicofactoren en interventielandschap centraal stond, verschuift in het derde vraagstuk de focus naar toetsing in de praktijk. Onderzocht wordt of een nieuwe preventieve interventie, genaamd Veilige Start, ontwikkeld met en bedoeld voor aanstaande ouders met een verstandelijke beperking die meerdere en complexe problemen ervaren en waar er concrete zorgen zijn over de veiligheid van het kind daadwerkelijk uitvoerbaar en effectief is voor deze doelgroep.

In **Hoofdstuk 7** wordt een studie beschreven naar de haalbaarheid, waardering en de eerste effecten van Veilige Start in een groep van vijf gezinnen. Ondanks de kleine steekproef, zijn de bevindingen voorzichtig



bemoedigend. Ouders en jeugdzorgwerkers herkenden grotendeels de werkzame elementen van de interventie, wat erop wijst dat de interventie toepasbaar is binnen deze complexe context. Daarnaast waardeerden de meeste ouders zowel de betrokken jeugdzorgwerker als de interventie zelf. Na afronding van de interventie, waren er verbeteringen in de veiligheid van het kind in alle gezinnen. Hoewel de veiligheidsscores bij aanvang al relatief laag waren – wat dus beperkte ruimte liet voor verdere verbeteringen – is elke afname betekenisvol, omdat signalen van onveiligheid duiden op acute bedreigingen die binnen 24 tot 48 uur moeten worden opgepakt. Daarnaast namen de veranderbare risicofactoren in drie van de vijf gezinnen af na interventie. Echter, de risico's bleven in de meeste gevallen in de midden- tot hoog risicocategorie, wat laat zien dat de problematiek in de gezinnen complex en kwetsbaar blijft, ondanks deze eerste verbeteringen. Dit onderstreept het belang van longitudinaal onderzoek om na te gaan of de geobserveerde verbeteringen op langere termijn behouden blijven en of zich in de tijd verdere afname van risicofactoren voordoet.

Om deze vragen te beantwoorden, richt **Hoofdstuk 8** zich op een longitudinale studie waarin de effecten van Veilige Start bij 13 gezinnen werden onderzocht, en werden vergeleken met 136 gezinnen met een kinderbeschermingsmaatregel vóór de geboorte. Gezinnen werden gevolgd van aanvang van de interventie tot twee jaar na geboorte. Verbeteringen in het door moeders zelf gerapporteerde welzijn van ouders en kind bleven uit, maar waren in beiden groepen vanaf aanvang relatief

hoog en bleven stabiel over tijd. Daarentegen werd een substantieel verschil gevonden in het aantal uithuisplaatsingen tussen beiden groepen: 15% in de Veilige Start groep tegenover 74% in de groep met een kinderbeschermingsmaatregel vóór de geboorte werd in de onderzoeksperiode uit huis geplaatst. Tevens namen de veranderbare risicofactoren significant af in beiden groepen. De afname leek groter in de groep met een kinderbeschermingsmaatregel vóór de geboorte, maar dit verschil verdween wanneer uitsluitend naar gezinnen werd gekeken zonder uithuisplaatsing. Dit suggereert dat Veilige Start het mogelijk maakt om het aantal uithuisplaatsingen aanzienlijk te reduceren, ook wanneer risicofactoren minder snel afnemen dan in situaties waarin een ingrijpende maatregel wordt opgelegd.



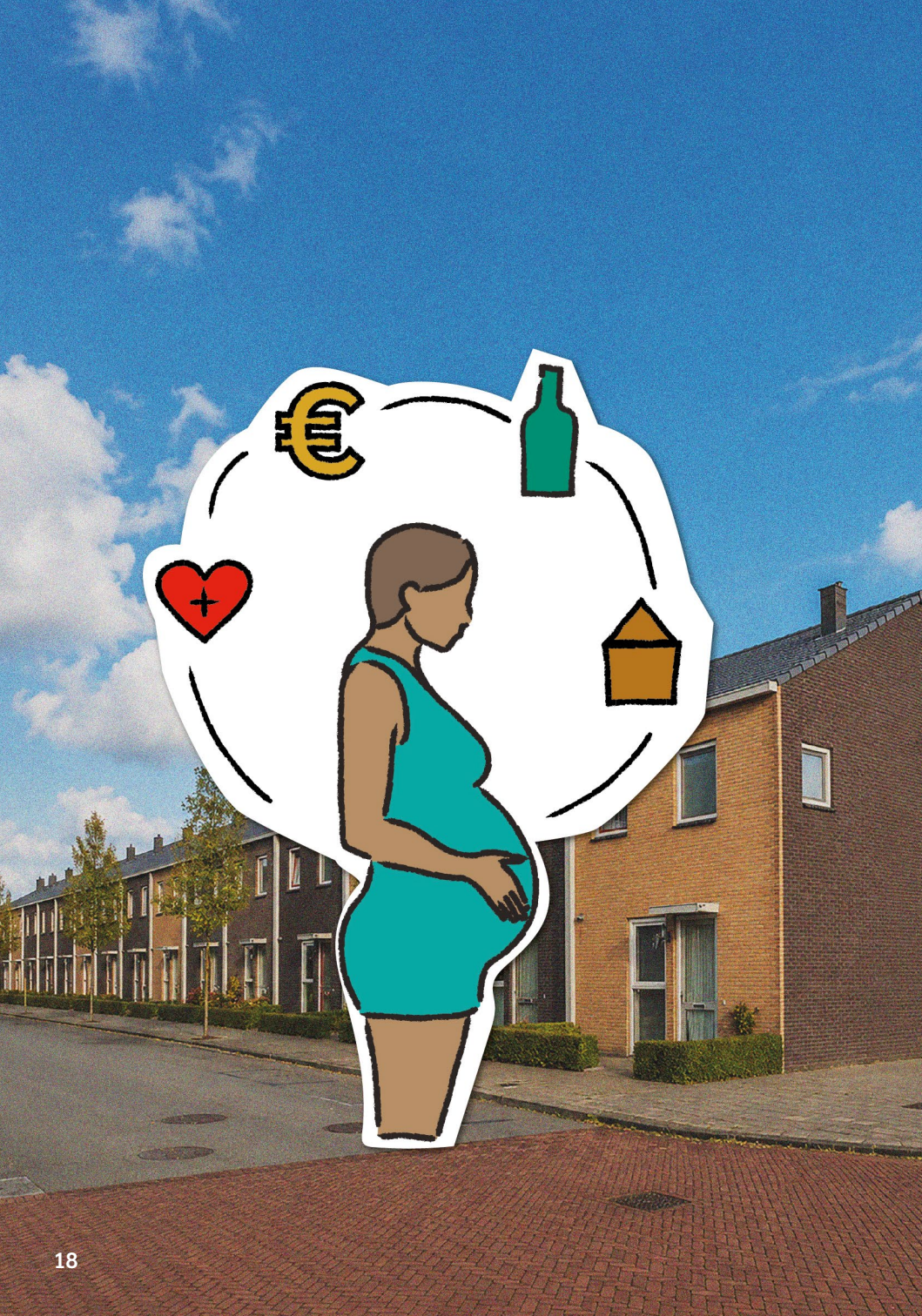
Gezamenlijk laten Hoofdstuk 7 en 8 zien dat een preventieve, vrijwillige en contextueel afgestemde interventie (Veilige Start) uitvoerbaar en gewaardeerd is, en bovendien samenhangt met een sterke afname van de kans op een uithuisplaatsing. Daarmee biedt het derde deel van het proefschrift empirische onderbouwing voor het perspectief dat in de eerdere hoofdstukken werd geschetst, namelijk dat tijdige en toegankelijke vrijwillige ondersteuning een veelbelovende aanpak zijn naast of in plaats van gedwongen kinderbeschermingsmaatregelen.

De bevindingen uit de drie vraagstukken vormen de basis voor de discussie, waarin eveneens drie kerninzichten centraal staan. Ten eerste laten de studies van dit proefschrift zien dat uitkomsten op het gebied

van de veiligheid van het kind niet primair worden verklaard door de verstandelijke beperking zelf, maar door de cumulatie van risicofactoren die gepaard gaat met de beperking. Ten tweede blijkt preventieve, tijdige ondersteuning cruciaal, juist omdat risico's zich vaak al tijdens de zwangerschap manifesteren. Ten derde lijken de bevinden erop te wijzen dat ouders met een verstandelijke beperking, ook wanneer zij te maken hebben met meervoudige en complexe problematiek, effectief ondersteund kunnen worden in het bieden van "goed genoeg" ouderschap, mits zij passende en duurzame ondersteuning ontvangen. Gezamenlijk suggereren de studies dat vrijwillige, op maat gemaakte interventies kunnen bijdragen aan het verminderen van cumulatieve risico's en uithuisplaatsingen kunnen terugdringen, waardoor ouders met een verstandelijke beperking én die opeenstapeling aan problemen met passende ondersteuning vaker thuis voor hun kinderen kunnen zorgen.

Tegelijkertijd maakt dit proefschrift zichtbaar dat er aanzienlijke lacunes bestaan in de beschikbaarheid, toegankelijkheid en systematische evaluatie van preventieve ondersteuning voor aanstaande ouders met een verstandelijke beperking en meerdere en complexe problemen, met name in de Nederlandse context. Tegen deze achtergrond lijkt het relatief hoge gebruik van kinderbeschermingsmaatregelen vóór de geboorte – en de oververtegenwoordiging van kinderen van ouders met een verstandelijke beperking binnen de kinderbescherming – niet enkel een afspiegeling te zijn van de beperking van ouders, maar juist die van een systeem waarin tijdige en passende vrijwillige ondersteuning onvoldoende toegankelijk en beschikbaar is. En waar in vergelijking met andere landen veel gebruik wordt gemaakt van drang en dwang, zonder dat daar een degelijke juridische basis voor is. Door afstand te nemen van een benadering gericht op tekorten en ouderschap bij ouders met een verstandelijke beperking te begrijpen als voorwaardelijk en ontwikkel-

baar binnen een bredere sociale context, biedt dit proefschrift ondersteuning voor een paradigmaverschuiving in denken en handelen: het waarborgen van veiligheid van kinderen begint bij het tijdig bieden van de juiste en passende ondersteuning aan ouders met een verstandelijke beperking met meerdere en complexe problemen, al vanaf het allereerste begin.





Chapter 2

General introduction

Historically, parenthood among people with intellectual disabilities was shrouded in taboo and social stigma, leading to discrimination, disadvantage, and exclusion from society (Aunos et al., 2020; Beltran-Arreche et al., 2025). The prevailing opinion was that they should not have children because they were supposed to be incapable of raising them. While such attitudes have not disappeared entirely, there has been a gradual shift in recent decades. Nowadays, society recognizes people with intellectual disabilities as full members with the same rights as other people, as articulated in The United Nations Convention on the Rights of Persons with Disabilities (2006). The Convention affirms the right to family life and parenthood for parents with intellectual disabilities, and emphasizes the responsibility of governments to ensure that parents with intellectual disabilities have access to adequate support to exercise their parenting rights. There is growing awareness that parents with intellectual disabilities can also become good enough parents and raise their children adequately, with support if necessary (e.g., Collings and Llewellyn, 2012; Guénoun et al., 2025; Koolen et al., 2020). Parenting with an intellectual disability is thus becoming increasingly well-known and accepted by society (Potvin et al., 2020).

Research in different disciplines has begun to focus more on parenting with intellectual disabilities. Most of the studies show that raising children is often a complex challenge for parents with intellectual disabilities (e.g., Aunos et al., 2008; Beltran-Arreche et al., 2025; Meppelder et al., 2015; McConnell et al., 2021; Feldman & Aunos, 2020). However, this is not solely due to the intellectual disability itself, but rather to a combination of risk factors that they often face and can arise at the individual, relational, and contextual levels (Feldman & Aunos, 2020). For example, parents with intellectual disabilities more often than other parents face histories of adverse childhood experiences, mental health issues, psychiatric and behavioral difficulties. (e.g., Lightfoot & Slayter, 2014; McConnell et al., 2011a, 2011b; O'Keeffe & O'Hara, 2008). Moreover, they often experience poverty, limited access to education and healthcare, stigma, and difficulty navigating complex systems of support (e.g., Glazemakers & Deboutte, 2013; Meppelder et al., 2015; Powell et al., 2017). This accumulation of risk factors can increase parenting stress (Meppelder et al., 2015), which is associated with less supportive parenting, more hostile attributions, ineffective parenting styles, and reduced sensitivity, thereby increasing risks to child development and safety (Aunos et al., 2008). Importantly, the challenges parents with intellectual disabilities face may already emerge during pregnancy, a critical transition period in which existing individual, relational, and contextual vulnerabilities can increase while resources to cope with the transition to parenthood are often limited (Lawler et al., 2015).

However, we do not yet understand which kinds of support parents need to face these challenges. Therefore, this thesis aims to gain insight into the support needs of parents with intellectual disabilities during and right after pregnancy in relation to child safety, the support available to them and the impact of a new preventive intervention.

Parents with intellectual disabilities

Intellectual disability is defined as 'limitations in intellectual functioning and in adaptive behavior that originate before the age of 22' (Schalock et al., 2021). Intellectual functioning refers to a person's mental capacities, such as learning and problem-solving. Adaptive functioning consists of a set of skills needed to adapt to social and societal demands: conceptual, social, and practical. The exact number of parents with intellectual disabilities is unknown, with estimates worldwide varying between 0.25% and 7% (e.g., Emerson et al., 2005; Llewellyn & Hindmarsh, 2015; MacLean & Aunos, 2010; Pixa-Kettner, 2008). Accurate figures are challenging to obtain due to the inherent imprecision of the definition, underreporting, stigma, and limited inclusion in population registries.

Parents with intellectual disabilities constitute a heterogeneous group. Not all parents with intellectual disabilities experience problems in their cognitive abilities, adaptive functioning, and the co-occurrence of risk factors to the same extent (Feldman & Aunos, 2020). Some parents are better equipped to navigate these challenges than others. This diversity directly influences both the parenting tasks parents can perform independently and the types and intensity of informal and formal support they require.

Recent research indicates that most parents with intellectual disabilities can raise their children "good enough", enabling them to grow up safely, provided they receive appropriate support, tailored to their needs (Collings & Llewllyn, 2012; IASSID, 2008; Koolen et al., 2020). The concept of 'good enough parenting' refers to a stable, caring and loving parenting of the child that adequately supports the child's development

(Winnicott 1965 in Hoghuni and Speight, 1998). This concept emphasizes that parents do not need to be perfect to meet their children's developmental needs. Expecting perfection in parenting is neither realistic nor necessary. It may, in fact, undermine the perceived competence of parents who can provide sufficiently responsive and supportive care (Winnicott 1965 cited in Hoghughi & Speight, 1998). From this perspective, support for parents with intellectual disabilities should not aim to achieve idealised or perfect parenting, but rather focus on enabling conditions in which 'good enough parenting' can be realized, as articulated in the fourteen conditions of good enough parenting (Zijlstra, 2012).

Supporting parents with intellectual disabilities

From a preventive perspective, supportive conditions should begin as early as possible in the transition to parenthood, starting during pregnancy, when people imagine themselves becoming parents, prepare for birth, and their parental role (Guénoun et al., 2025). While all parents face challenges during the transition to parenthood, parents with intellectual disabilities may require additional support to navigate pregnancy and early parenthood. Pregnancy thus offers a crucial window of opportunity for the early identification of risk factors and the provision of timely, tailored preventive support. Early interventions can promote healthy pregnancies, foster optimal early childhood development, and enhance the overall well-being of both the child and the family (Potvin et al., 2020).

Despite these opportunities, research shows that risk factors in expectant parents with intellectual disabilities are often identified and addressed at a later stage, sometimes around or after birth, and often only later in childhood, when concerns about the child's development and

safety become acute and sometimes beyond repair (St-Laurent et al., 2019). Identification of problems at a late stage is often associated with drastic measures, such as child protection involvement and removal from the home immediately after birth (McConnell et al., 2006). Studies indicate that children of parents with intellectual disabilities are over-represented in child protection services (CPS) (e.g., Dion et al., 2018; LaLiberte et al., 2017; McConnell et al., 2011a, 2011b; Willems et al., 2007), particularly children under the age of one (McConnell et al., 2011a). Moreover, it appears that these children have prolonged involvement with CPS and have an increased risk of out-of-home placement (OOHP) (e.g., Buchan & Gunn, 2007; McConnell et al., 2011a, 2011b; Pacheco et al., 2021; Willems et al., 2007). OOHP can have lasting negative effects on children's emotional, social, and cognitive development, as well as on the parent-child relationship (e.g., Ainsworth & Hansen, 2012, Orri et al., 2021). Although child protection measures aim to protect the child, they do not always have beneficial effects on the child and the family (Sterenborg et al., 2025). This underscores the importance of preventive intervention at an earlier stage, to prevent escalation and reduce the need for intrusive, drastic child protection measures. However, existing research offers little insight into whether voluntary interventions in an earlier stage could have prevented or limited this escalation.

Effective prevention requires a thorough understanding of the risks associated with unsafe circumstances for children, particularly in relation to child safety (De Castro & Van Dijk, 2017). However, existing evidence on risk factors associated with unsafe circumstances is primarily derived from studies in the general population (Assink et al., 2016) and remains limited for parents with intellectual disabilities (Lightfoot & Slayter, 2014). Moreover, this body of research provides little insight into how

such risks manifest during the prenatal period, nor does it adequately address the specific context of expectant parents with intellectual disabilities. As a result, important questions remain regarding which risk factors are already present during pregnancy, how these risks relate to child safety after birth in parents with intellectual disabilities, and how they can be addressed preventively.

In addition to the limited knowledge about risk factors during pregnancy among expectant parents with intellectual disabilities, preventive interventions for parents with intellectual disabilities remain scarce. While a wide range of evidence based preventive parenting programs exists for the general population (e.g., Nurse-Family Partnership as described in Mejdoubi et al., 2015), parents with intellectual disabilities are often explicitly excluded from these interventions, both in research and in practice, as general programs are frequently considered unsuitable for their needs (Glazemakers & Deboutte, 2013; IASSID, 2008). Most interventions for parents with intellectual disabilities are postnatal, and mainly focus on strengthening the parent-child relationship and parenting skills (e.g., VIPP-LD as described in Hodes et al., 2017; Home-based Parent Training Program as described in Feldman et al., 1992), but do not address the organizational and institutional environment in which these families function (McConnell et al., 2008). Far less is known about interventions offered during pregnancy. No comprehensive overview exists of the types of support available to expectant parents with intellectual disabilities, nor their effectiveness.

Interventions during pregnancy are generally provided on a voluntary basis, but questions have arisen about whether mandatory measures may be warranted when necessary to protect the interests of the unborn child. In the Netherlands, where the present studies take place, it is pos-

sible to intervene with mandatory child protection measures during pregnancy (i.e. pre-birth protection orders) when voluntary measures are ineffective or the parents are not open to support (2021, Article 255). However, Dutch law does not provide clear guidance on the legal status of the unborn child in this context, and there is no consensus on how early in pregnancy such measures can be imposed. This ambiguity raises the question of whether and how pre-birth protection orders currently exist and are used in different countries. Particularly in view of the overrepresentation of children of parents with intellectual disabilities in child protection services, this is a relevant question.

A new intervention: Safe Start

Given the scarcity of interventions specifically designed for expectant parents with intellectual disabilities facing multiple risks, and the limited evidence regarding the effectiveness of the few programs that do exist, there is a clear need for innovative, tailored support for these expectant parents during pregnancy. While voluntary preventive interventions offer opportunities to strengthen parenting skills and parent–child relationships, and mandatory pre-birth measures exist as a last-resort safeguard, neither approach fully addresses the gap in early, voluntary, and evidence-informed support for this population.

Therefore, Safe Start was developed by and for expectant parents with intellectual disabilities facing multiple and complex problems. The intervention aims to engage parents and their social networks in jointly identifying risks and strengths, and in organizing the necessary support to ensure a safe start for the child. It is a coordinating intervention in which the youth care workers do not provide direct care themselves, but instead draw up a safety plan in consultation with the family and their

network, and coordinate the care provided. The intervention starts during pregnancy, at 25-32 weeks of gestation, and continues until six months postpartum. The aim of Safe Start is threefold: (1) To achieve and ensure a safe environment and development for the child; (2) To enable parents to take the responsibility of parenthood, if necessary, with support; and (3) If the parents are not the primary caregivers of the child, to maintain the bond between parents and child intact.

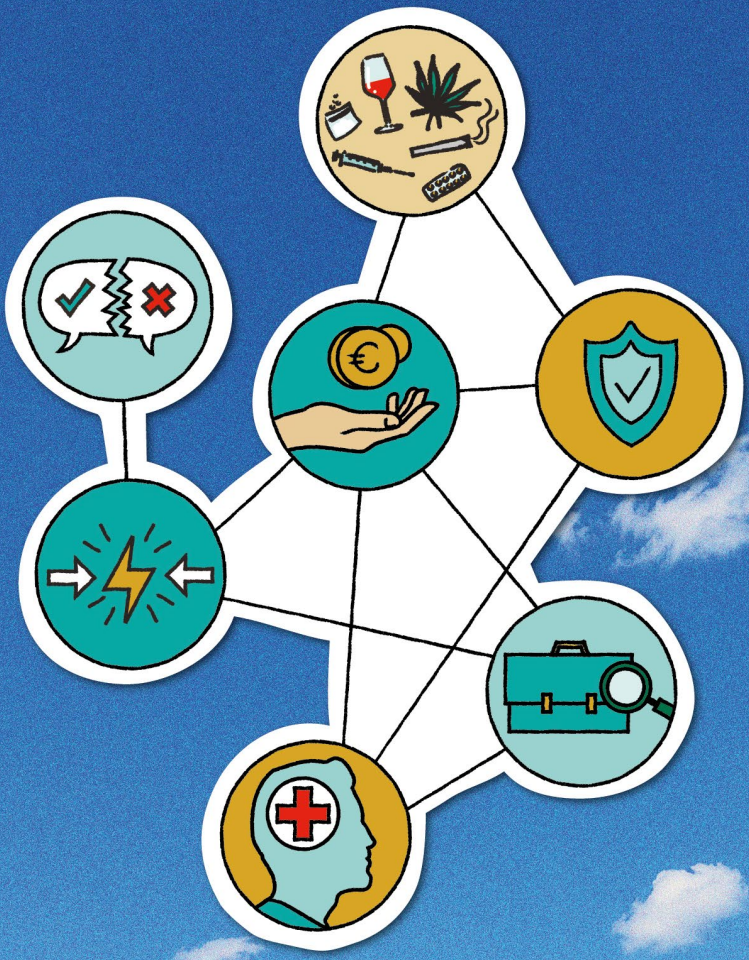
Safe Start is available in the Netherlands and is being used by a growing number of municipalities. However, despite its potential, no research has yet examined the feasibility or effectiveness of Safe Start, leaving critical questions about its implementation, acceptability, and impact on both parents' and children's outcomes unanswered.

The current research and thesis outline

Despite the growing attention for parents with intellectual disabilities in research, existing research focuses primarily on the postnatal phase of pregnancy and on situations where concerns already exist (Beltran-Arreche et al., 2025). There is limited empirical evidence on risk factors experienced by expectant parents with intellectual disabilities during pregnancy and how these relate to the safety of the child after birth. In addition, existing research provides no clear overview of the interventions available to this target group during pregnancy, nor of the feasibility and effectiveness of voluntary, preventive interventions in this early phase.

This thesis focuses on expectant parents with intellectual disabilities facing multiple and complex challenges, aiming to gain insight into the risk factors they experience during pregnancy in relation to child safety, the voluntary and mandatory interventions available for this group, and the feasibility and effectiveness of a new voluntary preventive intervention.

To understand which risk profiles interventions need to address for expectant parents with intellectual disabilities, **Chapter 3** presents a study on risk factors present in expectant parents with intellectual disabilities in child protection services and how these risk factors relate to the child's safety once born. Following on from this study, **Chapter 4** describes a study which investigated whether clusters of parents exist within this population who are similar in terms of risk factors. Next, to examine whether current interventions address these risks, a scoping review provides an overview of the voluntary preventive interventions available for expectant parents with intellectual disabilities and their effectiveness, as outlined in **Chapter 5**. As mentioned, pre-birth child protection orders may be imposed for these families in the Netherlands. **Chapter 6** analyses how this Dutch practice compares to other Western countries, identifying what is needed to protect children while supporting parents. To this end, Safe Start was developed. **Chapter 7** examines the feasibility of Safe Start, and **Chapter 8** evaluates its impact compared to pre-birth protection orders. The thesis concludes with a general discussion of the findings and implications.





Chapter 3

Expectant parents with intellectual disabilities in child protection: Risk factors for child safety

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Author contributions:

M. van Nieuwenhuijzen and B. Orobio de Castro developed the study concept. All authors contributed to the study design. Data collection was performed by T. Sterenborg and A. Zijlstra. Analyses were performed by A. Zijlstra. The first draft of the manuscript was written by A. Zijlstra and edited by M. van Nieuwenhuijzen, B. Orobio de Castro, and T. Sterenborg.

Abstract

Background: Newborns of parents with intellectual disabilities face higher risks in their environment for child unsafety, despite parents' good intentions. To help parents prevent unsafe circumstances, a good understanding of the risk factors faced by these parents is needed.

Methods: This casefile study examined (1) which risk factors were present for expectant parents with intellectual disabilities in child protection, (2) which domains of risk factors, and (3) whether a cumulation of risk factors was related to child safety.

Results: Expectant parents with intellectual disabilities in child protection before the child was born often experienced a cumulation of risk factors. Child, family, and care factors best predicted child safety. A cumulation of risk factors over multiple life domains increased the risks for child unsafety.

Conclusions: To reduce the risks of unsafe parenting conditions for newborns, preventive interventions for expectant parents with intellectual disabilities should address their needs from an ecological perspective.

Keywords: child protection services, child safety, parenting, parents with intellectual disability, pregnancy, risk factors.

Lay Summary

- Parents with intellectual disabilities in child protection often face multiple and complex problems, which increases the risks of unsafe parenting conditions once the child is born.
- Current interventions for families with multiple risks may still be too narrow in scope and too low in intensity and duration for extremely troubled families.
- To effectively intervene, it is important to take into account the remarkably high risks and cumulative risks of this specific population from an ecological perspective, in which the different protective and risk factors of the different life domains are considered in interaction with each other.

Introduction

Newborns of parents who have intellectual disabilities[1] face heightened risks of poorer developmental outcomes, starting from pregnancy to later development, such as preterm and low birth weight, mental health problems, and school- and work dropouts (e.g., Emerson & Brigham; 2014; Höglund et al., 2012a, 2012b; McConnell et al., 2008; Murray et al., 2010). These heightened risks seem not directly related to the intellectual disability itself but are a reflection of the multiple and complex problems these families often face (Meppelder et al., 2015; Wilson et al., 2013). This cumulation of risks may lead to unsafe parenting, such as inconsistency, low sensitivity, and even neglecting (e.g.,

1. Intellectual disabilities are defined as 'limitations in intellectual functioning and in adaptive behaviour that originates before the age of 22' (Schalock et al., 2021). The exact number of parents with intellectual disabilities is unknown, with estimates worldwide varying between 0.25% and 7% (e.g., Emerson et al., 2005; MacLean & Aunos, 2010; Pixa-Kettner, 2008).

Aunos et al., 2008; Lindberg et al., 2017; McConnell et al., 2021; Wickstrom et al., 2017). Although an intellectual disability in itself is thus not directly related to unsafe parenting, and other multiple and complex factors are at play, it has been observed that children of parents with intellectual disabilities are overrepresented in child protection services (CPS) in high-income countries (e.g., LaLiberte et al., 2017), particularly children under the age of one (McConnell et al., 2011a). In addition, it appears that these children have a prolonged involvement with CPS and have an increased risk of out-of-home placement (e.g., Buchan & Gunn, 2007; McConnell et al., 2011a, 2011b, 2021; Pacheco et al., 2021; Willems et al., 2007).

However, as recognized in several studies, parents with disabilities are capable of raising their children good enough, provided they are effectively supported in line with their needs (e.g., Collings and Llewlynn, 2012; IASSID, 2008). Even more specifically, parents with intellectual disabilities have the right to parenthood and family life, and State Parties are obliged to effectively and appropriately support these parents in enabling them to exercise this right (United Nations, 2006). To support parents with intellectual disabilities in preventing their children from unsafe parenting conditions, it is important to intervene as early as possible, even during pregnancy (e.g., O'Keeffe & O'Hara, 2008; Slayter & Jensen, 2019). Successful prevention depends on a good understanding of the risks that come with unsafe circumstances for the child (i.e. child safety) (De Castro & Van Dijk, 2017). However, this knowledge is limited to the general population (Assink et al., 2016) and even more limited to the population of parents with intellectual disabilities (Lightfoot & Slayter, 2014), and it does not apply to the specific population of expectant parents with intellectual disabilities in child protection. To fill this gap, the present study aimed to increase this knowledge by examining risk

factors in expectant parents with intellectual disabilities in child protection in relation to child safety.

Child safety can have various meanings. For example, safety measures in the home to protect the child (e.g., a stair gate) or safety measures when a child is injured. In this paper, we refer to child safety from a parenting perspective. From this sense, child safety is defined as: "the child can structurally rely on an adult who provides for his basic physical and emotional needs, who protects him from danger and who provides continuity and predictability in doing this" (Ten Berge & Bakker, 2005). Therefore, child safety refers to several aspects; the presence of regularity and stability; the child's physical and emotional care; a sense of security; and the absence of protection from violence and abuse (Ten Berge & Bakker, 2005). Child safety in CPS can therefore be indicated by three outcomes: a lower child's safety rating on risk- and safety assessment, out-of-home placement, and a longer duration of a CPM (Turnell & Murphy, 2014).

When specifically considering risk factors related to the three indicators of child safety, research over the years has shown that the duration of a CPM and out-of-home placement is best explained by child-related risk factors, such as the child's age, disability, and mental health problems (e.g., Busschers et al., 2016; Glisson et al., 2000). In addition to child factors, Busschers et al., (2016) found that characteristics of the CPM (such as a provisional CPM and a small number of case managers involved) and youth-care worker characteristics (such as gender and working experience) also have a large contribution to the variation in the duration of a CPM. Research on predictors related to the child safety rating is not known to the best of the authors' knowledge.

However, the studies mentioned above examined risk factors related to indicators of child safety in the general population and made no distinction between parents with and without intellectual disabilities. Despite parents' best efforts, it can be expected that the risk factors related to child safety are different for parents with intellectual disabilities, because of the cognitive disabilities they face (MacIntyre et al., 2019). For example, parents with intellectual disabilities may find themselves having problems with generalizing skills to other situations, adapting to the child's development, and stimulating the development of the child (Wilson et al., 2013). In addition to their cognitive vulnerabilities, parents with intellectual disabilities are often exposed to a cumulation of risk factors, which increases the levels of parenting stress (Meppelder et al., 2015; Wilson et al., 2013). Parenting stress is related to less supportive parenting, more hostile attributions, ineffective parenting styles, less sensitivity, and therefore higher risks for child safety (Aunos et al., 2008).

Factors affecting parenting stress in parents with intellectual disabilities are associated with all life domains, as described in the contextual-interactional model of Feldman and Aunos (2020). First, parents with intellectual disabilities tend to have less access to resources that are important in starting a family, such as financial resources and supportive social networks (e.g., IASSID, 2008; Meppelder et al., 2015; Powell et al., 2017). People with intellectual disabilities not only have, on average, smaller social networks of family and friends; their access to care is also poorer than for other families, due to limited resources, barriers to asking for and finding support (e.g., complex reading, bureaucracy), negative attitudes of professionals towards people with intellectual disabilities becoming parents, and professionals' lack of knowledge, time, and material resources to effectively work with these parents (Castell & Stenfert

Kroese, 2016; Glazemakers & Deboutte, 2013). Furthermore, parents with intellectual disabilities often experience problems of their own, such as poor physical health, high levels of mental health problems, psychopathology (McConnell et al., 2011a), and adverse childhood experiences (Lightfoot & Slayter, 2014; O'Keeffe & O'Hara, 2008). Finally, parents with intellectual disabilities often have children with special needs (McGaw et al., 2010).

To detect and support highly vulnerable expectant parents with intellectual disabilities and multiple and complex problems, it is important to know which specific risk factors are present and which domains of risk factors affect child safety, even during pregnancy. To the best of our knowledge, this has not yet been examined. Only one study examined the risk factors of this particular group in relation to referral to CPS at birth (Brown et al., 2018). It was found that the most important risk factor was maternal psychotic disorder, followed by risk factors concerning prenatal care. However, this study did not include risk factors in all life domains, while it can be expected that a cumulation of risk factors in all life domains threatens the child's safety, with expectant parents with intellectual disabilities subjected to child protection even before the child was born. The present study, therefore, aimed to increase this knowledge by examining:

1. Which risk factors in relation to child safety are present in expectant parents with intellectual disabilities subject to child protection?
2. Which domains of risk factors are (primarily) related to child safety?
3. Whether a cumulation of risk factors over multiple domains is related to child safety?

We hypothesized (1) that expectant parents with intellectual disabilities subject to child protection experience (a cumulation of) risk factors in all seven domains; (2) that risks are present in each domain and (3) that a cumulation of risks over domains is related to child safety.

Methods

Sample

In the present study, 110 closed casefiles of children (50.9% girls; 49.1% b0, *SD* = 29 days), were analyzed on risk factors in relation to child safety. The CPM was executed by a Dutch national CPS organization for children and their parents with intellectual disabilities. In the Netherlands, two different CPMs can be imposed before birth if there is a high chance that the child's safety is in jeopardy once the child is born: a family supervision order (FSO) and state custody. During the FSO (*n* = 103; 93.6%), the parents retain custody of their child but are obliged to cooperate with the advice of the youth-care worker. The youth-care worker is a case-coordinator, who initiates care, but does not carry out the care himself. State custody (*n* = 7; 6.4%) is imposed in case the parents have not yet reached the adult age (18 years) or when the safety of the child cannot be guaranteed within an acceptable period; as a result, the parents will lose custody of their child (Person and Family Rights, 2021a, 2021b). Of the children with an FSO, 47.3% escalated to state custody. For these families, only the casefiles of the FSO were considered in this study.

Inclusion criteria were: 1) the child had a CPM before he/she was born, 2) the mother had an intellectual disability according to registration records, 3) the casefile was closed between 2015 and 2019, and 4) a civil report or a risk and safety assessment was needed to be present in the casefile. Taking these criteria into account, a sample of 460 out of 1670

casefiles was established. From this sample, 110 casefiles were randomly sampled. The number of casefiles was based on a-priori power analysis in G Power 3.1.9.2 (Faul et al., 2009), which indicated a required sample size of N = 103 for one-tailed logistic regression, with an expected correlation between the nominal predictors of .30 and a power of .90. Thus, the sample size will suffice to detect the effects of the individual predictors and the cumulative effects.

In contrast to the registration records, the casefile study revealed that only 98.2% (n = 108) of the children had a mother with an intellectual disability. However, the two cases with a mother without an intellectual disability were still included because the intellectual disability could be suspected based on their adaptive functioning. The other 108 mothers were known to have an intellectual disability based on diagnostic reports kept in the casefile, in which the IQ scores were known for 77 mothers, with a mean score of 66 (SD = 9). The IQ scores of only 27 fathers were known, with a mean score of 67 (SD = 11).

Procedure

The study procedure has been approved by the Ethics Review Board of the University of Amsterdam (2021-CDE-1872). Under the laws and regulations regarding a CPM, it is allowed to examine casefiles without active consent from those involved for scientific research (Data processing, privacy, and consent, 2022). The data cannot be traced back to the participants, and the lives of those involved are not disproportionately harmed.

The youth-care worker keeps a casefile. The casefiles included reports from (previous) externally involved care settings (e.g., diagnostic reports) as well as council reports, court orders, and internal reports (e.g., inter-

vention plan, risk and safety assessment). The independent trained researchers, screened the qualitative information from the casefiles for problems present in the families from the start of the CPM until 6 months after birth, using a structured coding system, in which the definitions and criteria of the risk factors were well-defined. The casefiles coded in the period between June and December 2021. Of the 110 casefiles, a random sample of 20% (n = 22) was independently coded by both researchers to indicate inter-rater reliability. Cohen's Kappa (K) was calculated for all risk factors and had a mean score of K = .81, indicating excellent inter-rater reliability (Allen et al., 2014). The agreement between the two researchers was 91.9%. Disagreements were resolved jointly.

The coding system is based on Bodden and Deković' (2016) ecological overview of risk factors in families with multiple and complex problems referred to youth-care. The risk factors in this framework are considered to place the child at a heightened risk of developing problems. The risk factors are categorized into seven life domains, based on the ecological-transactional model of family functioning (Bodden & Deković, 2016). The life domains are child, parent, parenting, family functioning, contextual, social, and care.

The child domain includes psychological and psychosocial problems of the child (only relevant to the target group of (unborn) babies), (cognitive) disabilities, and victims or witnesses of abuse, neglect, and domestic violence. The parent domain refers to psychological and psychosocial problems of the parent, such as psychiatric problems, criminal behavior, and addictions. (Cognitive) disabilities and a burdened past of adverse childhood experiences are also included within the parent domain. The parenting domain concerns childrearing skills, such as inconsistent chil-

drearing and a disbalance between parenting capacity and load, which are assessed by professionals during pregnancy and when the child is born. The family functioning domain relates to disorders within the family, such as conflicts, bad cohesion, and communication problems. The contextual domain concerns negative life events, financial problems, and low socio-economic status, such as education and income level. The social domain covers disturbances within the social network of the family, such as a poor social network or conflict with neighbors. Finally, the care domain refers to a long history of care and out-of-home placement (Bodden & Deković, 2016).

Measures

Risk factors

Risk factors were scored as 'present' (1) if there was a description in the casefile that matched the criteria as operationalized in the coding system. The factor was scored as 'not present' (0) if there was no information present or if it was specifically noted in the casefile that the risk factor was not present. The risk factors were scored separately for the mother and father, and before and after birth. For the analyses, the number of risk factors within each life domain (child, parent, parenting, family functioning, contextual, social, and care) was summed, resulting in a sum score for each life domain. The sum of risk factors of each life domain was considered, rather than each individual risk factor, to prevent data fishing in a large number of separate tests (Evans et al., 2013). Furthermore, a cumulative risk factor over all the domains was established, which consisted of the sum of the number of domains on which risk factors were present, ranging from 0 to 7. The domains and the studied risk factors are presented in the first column of Table 1.

Child's safety

The child's safety was estimated with three indicators: the child's safety rating, the duration of the CPM, and out-of-home placement within 6 months after birth. First, the child's safety rating was established with the use of a standardized checklist for risk- and safety assessment used by the CPS organization, based on the validated LIRIK (Bartelink et al., 2015). Example items of the checklist are: 'insufficient skills to cope with the child's disability' and 'substance use problems'. The checklist was filled-in by the youth-care worker, based on information provided by and discussed with the family. The final child safety rating was established in consultation with colleagues and a behavioral scientist, varying between 1 to 10, where '1' means the child is considered unsafe, and '10' means the child is considered completely safe. Second, an out-of-home placement was scored as 'yes' (1) if the child was placed out-of-home within 6 months after birth. The child might have returned home in the same period, but in those cases, the score remained 'yes'. Third, the duration of the CPM was operationalized as shorter than 2 years (0), versus longer than two years (1). This dichotomy is based on Slot et al. (2001) who questioned whether a CPM would be effective if there was no improvement in the child's safety after 2 years.

Table 1

Descriptives of the domains, present risk factors, and outcome measures

Domains and outcomes	*N*	Possible range	Standardized *M*
Child domain	***110***	***0-19***	***0.19***
Physical abuse			
Domestic verbal violence			
Domestic physical violence			
Medical problems [a]			
Physical neglect [a]			
Emotional neglect [a]			
Emotional abuse [a]			
Medical risk [a]			
Physical disability [a]			
Life-threatening disease [a]			
Syndrome problems [a]			
Sensory disability [a]			
Cognitive disability [a]			
Chronic disability [a]			
Profound multiple disabilities [a]			
Sexual abuse [a]			
Parent domain	***110***	***0-30***	***0.27***
Cognitive disability			
Mental problems			
Psychiatric problems			
Emotional/physical neglect/abuse in own childhood			
Health problems both parents			
Drug (ab)use			
Justice contacts			
Domestic violence in own childhood			
Sexual abuse in own childhood			
Alcohol (ab)use			
Suicidal thoughts			

M (SD)	*n* (%)	*n* (%) during pregnancy	*n* (%) after birth	*n* (%) mother	*n* (%) father
		61 (55.5%)	3 (2.7%)		
		76 (69.1%)	22 (20.0%)		
		53 (48.2%)	12 (10.9%)		
	40 (36.4%)				
	39 (35.5%)				
	29 (26.4%)				
	19 (17.3%)				
	13 (11.8%)				
	2 (1.8%)				
	2 (1.8%)				
	1 (0.9%)				
	1 (0.9%)				
	0 (0.0%)				
	0 (0.0%)				
	0 (0.0%)				
	0 (0.0%)				
				108 (98.2%)	51 (46.4%)
				100 (90.9%)	74 (67.3%)
				56 (50.9%)	42 (38.2%)
				49 (44.5%)	11 (10.0%)
	42 (38.2%)				
				40 (36.4%)	40 (36.4%)
				26 (23.6%)	40 (36.4%)
				28 (25.5%)	6 (5.5%)
				27 (24.5%)	5 (4.5%)
				22 (20.0%)	25 (22.7%)
				24 (21.8%)	9 (8.2%)

Domains and outcomes	*N*	Possible range	Standardized *M*
Prison			
Suicide attempts			
Life-threatening disease one or both parents			
Physical disability			
Sensory disability			
Parenting domain	***110***	***0-8***	***0.51***
Inadequate parenting skills			
Emotional/physical neglect of other children (*n* = 78)			
Inconsistent parenting			
Emotional/physical abuse of other children (n = 78)			
Imbalance parenting capacity versus parenting load			
Family functioning domain	***110***	***0-6***	***0.45***
Relational problems			
Conflicts within the family			
Bad cohesion			
Divorce			
No contact with the parent			
Contextual domain	***110***	***0-14***	***0.52***
Burden past			
Financial problems			
Unemployment			
On welfare			
Housing problems			
Statutory debt restructuring			
Debts			
Social domain	***110***	***0-4***	***0.31***
Non/small social network			
Police involvement within the family			
Conflicts with neighbours			

M (SD)	*n* (%)	*n* (%) during pregnancy	*n* (%) after birth	*n* (%) mother	*n* (%) father
				5 (4.5%)	20 (18.2%)
				15 (13.6%|)	5 (4.5%)
	5 (4.5%)				
				3 (2.7%)	1 (0.9%)
				1 (0.9%)	3 (2.7%)
		102 (92.7%)	38 (34.5%)		
	62 (79.5%)				
		86 (78.2%)	33 (30.0%)		
	53 (68.0%)				
		72 (65.5%)	25 (22.7%)		
	75 (68.2%)				
	71 (64.5%)				
	62 (56.4%)				
	41 (37.3%)				
				8 (7.3%)	36 (32.7%)
				96 (87.3%)	45 (40.9%)
				84 (76.4%)	54 (49.1%)
				84 (76.4%)	40 (36.4%)
				64 (58.2%)	38 (34.5%)
				63 (57.3%)	45 (40.9%)
				60 (54.5%)	27 (24.5%)
				55 (50.0%)	39 (35.5%)
				72 (65.5%)	38 (34.5%)
	50 (45.5%)				
	23 (20.9%)				

Domains and outcomes	*N*	Possible range	Standardized *M*
Care domain	***110***	***0-3***	***0.46***
Avoiding care			
Acceptance problems related to the CPM			
Large number of care involved [b]			
Cumulative risk over the domains	***110***	***0-7***	
Outcomes			
Child's safety rating	78	0-10	
Out of home placement ('yes')	110		
Duration of the CPM (> 2 years)	110		

a. The percentages may be biased because if the child was placed out of home, and there was no information available, the factors were scored as 'missing'.
b. More than 5 care trajectories before start CPM.

Data analysis

Statistical analyses were performed using IBM Statistics SPSS 25. First, the descriptive data were analyzed to identify which risk factors were relatively common in expectant parents with intellectual disabilities subject to child protection (aim 1). Second, to identify which domains of risk factors were (primarily) related to the child's safety (aim 2), three separate multivariate (logistic) linear regression analyses, with method 'Forward', were conducted with the three indicators of the child's safety as dependent variables, and the seven domains as independent variables. Finally, to test whether a cumulation of risk factors over multiple domains was related to the child's safety (aim 3), three univariate (logistic) regression analyses were conducted with the three indicators of the child's safety as dependent variables, and the cumulative risk over the domains as independent variable.

M (SD)	*n* (%)	*n* (%) during pregnancy	*n* (%) after birth	*n* (%) mother	*n* (%) father
	62 (56.4%)				
	50 (45.5%)				
	38 (34.5%)				
6.37 (0.81)					
5.51 (2.06)					
	54 (49.1%)				
	54 (49.1%)				

Before these analyses were interpreted, the assumptions of linearity, independence of errors, and multicollinearity were tested (e.g., Field 2009). None of the assumptions were violated. However, the scatterplots of the analysis with the cumulative risk factor over the domains as the independent variable and the child's safety rating as the dependent variable were skewed. This may suggest that there was heteroscedasticity in this single analysis, and therefore the results of this analysis need to be interpreted carefully.

Results

Prevalence of risk factors

To examine which risk factors were present in expectant parents with intellectual disabilities subject to child protection (aim 1), the percentages of present risk factors were inspected (Table 1). When inspecting these percentages, it is striking that some risk factors were relatively common (more than 50%). In the child domain, during pregnancy, children were frequently (55.5%) exposed to physical abuse (such as

physical abuse towards the mothers' abdomen) and to domestic verbal violence (69.1%). In the parent domain, parents often had mental problems (mothers 90.9%; fathers 67.3%), and mothers often had psychiatric problems (50.9%). In the parenting domain, parents were expected to have inadequate parenting skills (92.7%) and they were likely to abuse and neglect their other children (abuse 68%; neglect 79.5%). Furthermore, in the family functioning domain, the families often experienced relational problems (68.2%), conflicts within the family (64.5%), and bad cohesion (56.4%). Mothers often had a burdened past (87.3%), financial problems (76.4%), debts (50%), and were often unemployed (76.4%). Furthermore, mothers were often on welfare (58.2%) and statutory debt restructuring (54.5%), and they often had housing problems (57.3%). Socially, mothers often had a non/small social network (65.5%). Finally, in the care domain, these families were likely to avoid care (56.4%).

Cumulatively, on average families experienced risk factors within six of the seven life domains (M = 6.37, SD = 0.71), while 60 families (54.5%) experienced cumulative risk in all seven domains.

Associations between the domains and the child's safety

To identify which domains of risk factors were (primarily) related to the child's safety (aim 2), predictors and outcomes were correlated, and three multivariate regression analyses were conducted. Concerning the child's safety rating, the results showed that risks in the child and social domain were correlated with the child's safety rating (see Table 2). The child domain explained most variance (8%) in the child's safety rating. A negative relationship was found between the child domain and the child's safety rating, which means the more child risk factors present, the lower the child's safety rating (see Table 3). After entering the child

domain into the regression equation, no other domains significantly explained additional variance. However, as can be seen in Table 2, almost all the other factors were positively correlated with the child domain, which suggests that variance in the other domains was captured in the regression analysis through the child domain.

Table 2

Pearson correlations between the child's safety rating and domains

Domains	***1***	**2**	**3**	***4***	***5***	***6***	***7***	***8***
1. Child's safety rating								
2. Child domain	–0.27*							
3. Parent domain	0.01	0.38*						
4. Parenting domain	–0.10	0.20*	–0.16					
5. Family functioning domain	–0.09	0.43*	0.10	0.22*				
6. Contextual domain	–0.15	0.35*	0.54*	0.13	0.23*			
7. Social domain	–0.25*	0.43*	0.41*	0.09	0.24*	0.42*		
8. Care domain	–0.11	0.05	0.08	–0.40	0.10	0.22*	0.23*	

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 3

Associations between the domains and the child's safety rating (n = 78)

Domains	***B***	***SE B***	***t***
Model 1			
Constant	6.45	0.44	
Child domain	–0.27	0.11	–2.48*

Note. $R^2 = .08$, $F(7, 76) = 6.15$, $p = .015$).
* $p < .05$. ** $p < .01$. *** $p < .001$.

Concerning out-of-home placement, the results of the multivariate logistic regression showed that out-of-home placement was best explained by the family functioning domain. This model was accurate for 62.7% of the cases. Nevertheless, the model with the family functioning and care domain was even better in predicting out-of-home placement. This model was accurate for 66.4% of the cases. The coefficients of both models are presented in Table 4. Both domains had a positive relationship with out-of-home placement, which means the more risk factors present within both domains, the higher the chance for out-of-home placement.

Finally, to predict the duration of the CPM, the results of the multivariate logistic regression analysis showed that only the care domain explained the duration of the CPM. The model was accurate for 62.7% of the cases. There was a negative relationship between the care domain and the duration of the CPM, which means the more risk factors present within the care domain, the smaller the chance of a long duration of the CPM (see Table 5).

Table 4

Associations between the domains and out of home placement (N=110)

Domains	*B*	*SE B*	*Exp(B) [95% CI]*
Model 1			
Constant	−1.07	0.44	0.35
Family functioning domain	0.38	0.14	1.47 [1.11, 1.94]**
Model 2			
Constant	−1.94	0.57	0.14
Family functioning domain	0.40	0.15	1.49 [1.11, 1.98]**
Care domain	0.61	0.23	1.84 [1.18, 2.89]**

Note. Model 1: R^2 = .01 (Hosmer & Lemeshow), .07 (Cox and Snell), .09 (Nagelkerke). Model ($X^2(1) = 7.87$, $p = .005$). Model 2: R^2 = .06 (Hosmer & Lemeshow), .13 (Cox and Snell), .18 (Nagelkerke). Model ($X^2(1) = 15.58$, $p = .000$).
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5

Associations between the domains and the duration of the CPM (N=110)

	B	*SE B*	*Exp(B) [95% CI]*
Model 1			
Constant	0.65	0.35	0.60
Care domain	–0.51	0.22	.60 [0.40, 0.92]**

Note. Model 1: R^2 = .01 (Hosmer & Lemeshow), .05 (Cox and Snell), .07 (Nagelkerke). Model ($X^2(1) = 5.78$, $p = .016$).
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 6

Association between the cumulative risk over the domains and the child's safety

	B	*SE B*	*ß*	*Exp(B) [95% CI]*
The child's safety rating (n = 78)				
Constant	9.78	1.81		
Cumulative risk over the domains	–0.66	0.28	–0.26	
Out–of–home placement (n = 110)				
Constant	–3.81	1.69		0.02
Cumulative risk over the domains	0.59	0.26		1.81 [1.08, 3.01]*
Duration of the CPM (n = 110)				
Constant	1.81	1.55		6.13
Cumulative risk over the domains	–0.29	0.24		0.75 [0.47, 1.20]

Note. The child's safety rating: R^2= .07, $F(1, 76) = 5.64$, $p = .020$). Out-of-home placement: R^2 = .01 (Hosmer & Lemeshow), .05 (Cox and Snell), .07 (Nagelkerke). (X^2 (1)= 5.63, p = .018). Duration of the CPM: (X^2 (1) = 1.48, $p = .224$).
* $p < .05$. ** $p < .01$. *** $p < .001$.

Association between the cumulative risk over the domains and the child's safety

To test whether cumulative risk over the domains explained the child's safety (aim 3), three univariate regression analyses were conducted. The cumulative risk over the domains significantly accounted for 7% of the variance in the child's safety rating. A negative relationship was found between the cumulative risk over the domains and the child's safety rating, which means the more domains with risk factors were present, the lower the score on the child's safety rating. The cumulative risk over the domains also significantly predicted out-of-home placement. This model was accurate for 50.9% of the cases. The model indicated that the more domains with risk factors present, the higher the chance for out-of-home placement. The cumulative risk over the domains did not significantly predict the duration of the CPM (see Table 6).

Discussion

This study examined risk factors in expectant parents with intellectual disabilities in relation to the child's safety. To prevent stigmatization of parenting with intellectual disabilities, we would like to reiterate that the results of this study only regard expectant parents with intellectual disabilities who were subjected to CPS before the child was even born. In line with our hypotheses, the results show that expectant parents with intellectual disabilities in child protection experience a broad range and a cumulation of risk factors in all life domains. The child's safety is best explained by risk factors within the child, family functioning, and care domain.

Comparing our results with the percentages of risk factors of other high-risk populations who were referred to care, but without an intellectual

disability and a CPM (Bodden & Deković, 2016; Fernandez, 2007), it can be concluded that in our study more families experienced more risk factors. For example, 68.2% of our families had relational problems (vs 33.8% in Bodden & Deković; 13.7% in Fernandez) and 76.4% of the mothers and 49.1% of the fathers had financial problems (vs 59% in Bodden & Deković; 31.4% in Fernandez). Also, we found that more than half of our families (54.5%) experienced risk factors concurrently in all life domains. It was not possible to compare this result with other studies. With some caution, it can thus be concluded that our families are more troubled than other high-risk populations. This is not completely surprising, since experiencing multiple and complex problems is the main reason for imposing a CPM (Buysse et al., 2010; Slot et al., 2001). Yet the extent to which risk factors accumulate over all life domains for the majority of families is striking and had not been documented before.

The importance of the cumulative risk in predicting the child's safety rating, at first sight, seems odd when considering the result that the child's safety rating was best predicted by risk factors in the child domain. However, it seems like the other domains affected the child's safety rating through the child domain, which was also confirmed in the correlation analysis and the regression predicting the child's safety rating by the cumulative risk over all domains. It is widely recognized that the risk for child unsafety does not have a single cause, but is a result of a cumulation of the presence of multiple risk factors (Brown et al., 1998; Mulder et al., 2014). The high correlations between the domains may have impacted the statistical power to disentangle unique contributions in regression analysis predicting the child's safety rating.

Cumulative risk also has an important role in predicting out-of-home placement, given that the odds of out-of-home placement increased

when families experienced risk factors over multiple life domains. Moreover, this study showed that out-of-home placement was best predicted by the model with the family functioning and care domain. This can perhaps be explained by the fact that common risk factors within these domains (relational problems, conflicts within the family, bad cohesion in the family) are presumably the main focus of the care families received. On top of that, families often avoided care (care domain), which may increase the chances of out-of-home placement. These findings are contradictory to results previously found, which showed that child mental health problems better predicted out-of-home placement (e.g. Farmer et al., 2008; Park et al., 2007). We studied a younger group, in which mental health problems of children were not (yet) present. To the best of the authors' knowledge, risk factors related to out-of-home placement in newborns have not previously been studied.

Surprisingly, the more risk factors present within the care domain, the smaller the chance of a long duration of the CPM. Considering the risk factors within this domain (avoiding care, acceptance problems related to the CPM, a large number of care involved before start CPM), we expected that care factors increased the chance for a long duration. Also, against all expectations, we did not find that a cumulative risk over the domains was related to the duration. A possible explanation for both findings is that our study only included the duration of the first CPM, while for 47.3% of the children, the FSO escalated to state custody. Thus, for these families, a shorter duration indicated larger severity of problems. It is also possible that we obtained anomalous results because we did not include characteristics of the youth-care worker (such as work experience), while previous research has shown that 13-21% of the variation in the duration is due to these characteristics (Busschers et al., 2016; Stams et al., 2010).

Concluding, in line with our hypothesis, the results of the current study seem to endorse that it is not parents' intellectual disability in itself that leads to unsafe parenting conditions, but the cumulation of developmental and contextual problems, starting from parents' own youth, that seems to influence the child's safety.

When interpreting the results, several limitations should be taken into account. First, the current sample was very specific, consisting of parents with disabilities who were subjected to CPS before the child was even born, which can lead to an overestimation of the impact of parenting with intellectual disabilities on the child's safety (Emerson et al., 2015; Powell et al., 2017). Moreover, the variance in risk factors could have been limited due to the specific sample, which may (partly) explain why no or weaker associations between the risk factors and outcomes were found, also known as 'reduction of range' (Kelley & Preacher, 2012). Even though the sample size of 110 was sufficiently large to find medium effects with high power within this restricted range (Faul et al., 2009), clearer relations may exist when also including parents who are not subject to child protection orders.

Second, the data collection method – a casefile study – has its limitations. Casefiles within CPS are likely to be incomplete (Stams et al., 2010). It is, therefore, possible that the information from the casefiles was not representative, which means that there is a chance of bias in the assessment of risk factors and in the relationships between the domains and the child's safety. Furthermore, professionals may have under- or over-reported risk factors for child safety. Underreporting may be due to insufficient knowledge of signs and risk factors for child abuse (Gubbels et al., 2021). Overreport may be due to professionals' attitudes or prejudice towards parents with intellectual disabilities, or a 'halo effect'

where the presence of some risks is unwarrantedly generalized to the assumption that other risk factors will be present too (Proctor & Azar, 2013). Despite these limitations of casefile research in parents with intellectual disabilities, a casefile study also has several advantages. Practically, it is the least burdensome for both clients and organizations (Zegers & Wollersheim, 2012). More importantly, it concerns the actual information and decisions that are made in practice, and may therefore be most directly relevant to families.

Finally, the results regarding the child's safety rating can be biased because this is a clinical judgment and the instrument is not validated. It is widely recognized that the validation performance of clinical judgments is questionable (van der Put et al., 2017). Nonetheless, the use of clinical instruments is relatively common in CPS. Moreover, the child safety rating was not only based on the professional opinion of the youth care worker involved but it was made in consultation with colleagues and the behavioral scientist.

Although the aforementioned limitations may have affected the results, the current study is, to our knowledge, unique in its focus on this specific population, and the first that provided insight into present risk factors in expectant parents with intellectual disabilities discharged to child protection even before the child was born, and which domains of risk factors affected the child's safety. The results of this study contribute to the scientific literature on parenting among parents with intellectual disabilities and underline the need for effective preventive interventions for expectant parents with intellectual disabilities in order to reduce the risks of unsafe circumstances for the child. To get a better understanding of the risk factors that influences child safety in parents with intellectual disabilities, it is recommended for follow-up research to further

expand the framework of risk factors, including youth-care worker characteristics, and also include protective factors. Also, additional interviews with caseworkers, clients, and other involved professionals are needed, to further examine the specific needs of these families.

Based on the current results, we recommend for the (further) development of supportive interventions to take the remarkably high risks and cumulative risks of this specific population into account, rather than the intellectual disability itself, in understanding unsafe circumstances for the child. In doing so, it is important to use an ecological approach when working with these families, where the risk and protective factors of the different domains are considered in interaction with each other (Feldman & Aunos, 2020). For example, in teaching parents with intellectual disabilities to cope with their child's crying, it is not only important to pay attention to parents' empathy, which may be limited due to the cognitive and adaptive disabilities they face, but also to the interpersonal traumas parents' may have experienced (Hammarlund et al., 2022). From these traumas, parents themselves have learned behavior and examples of how to deal with a child crying. In addition, the traumas may have limited their empathy. Finally, as the accumulation of risk factors related to child safety is already present during pregnancy, it is important to support these parents in an early stage, even during pregnancy, to shift away from a crisis-driven model (O'Keeffe & O'Hara, 2008).

Besides these specific recommendations, we would like to provide some more general recommendations for working effectively with parents with an intellectual disability based on previous research. First, to tailor the intervention to parents' needs arising from the intellectual disability, interventions must be skill-focused, use behavioral strategies, are home-based, long-term, and intensive (Aunos & Pacheco, 2021;

Feldman, 1994; Koolen et al., 2020). Furthermore, the intervention must be in partnership with the family and the informal network of the family, to increase resilience in parents with intellectual disabilities (Atkin & Stenfert Kroese, 2021; Scheffers et al., 2020). The professional needs to be supportive and tailored to the needs of parents with intellectual disabilities, to promote working alliance and increase parents' trust in support (Hanson et al., 2023). Moreover, the professional should know the rights of children and the rights of parents with intellectual disabilities (Hanson et al., 2023).

Unfortunately, current preventive interventions specifically designed for parents with intellectual disabilities are scarce and do not include all seven key elements to effectively work with parents with intellectual disabilities (Zijlstra et al., 2023). Given the rights of parents with intellectual disabilities to adequate and effective support in raising their children, it is strongly recommended to implement a youth care system in which preventive continuous sustainable support, based on effective key elements described above, can be provided to families with intellectual disabilities, in conjunction with periods of more intensive help tailored to the family. In doing so, professionals should be supported, with training and supervision in working with parents with intellectual disabilities to fit the needs of these families. Moreover, as professionals often lack the time and materials in implementing this, professionals must be supported in this by policy regulations, such as reducing the caseload so that the professional has more time for the family.

Conclusion

This study shows that expectant parents with intellectual disabilities subject to child protection before the child is born, experience a cumulation of risk factors over multiple life domains, which increase the risks for the child's safety once the child is born. This indicates that it is not the intellectual disability itself that leads to unsafe conditions for the newborn child, but the cumulation of problems that affects the child's safety. The current findings suggest that preventive interventions for this specific group should therefore address their needs from an ecological perspective. By intervening with effective interventions that are directed to the specific needs of this group in an early stage, even during pregnancy, unsafe conditions for the newborn can potentially be prevented.





Chapter 4

Exploring profiles of families of parents with intellectual disabilities in child protection: A cluster analysis

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Author contributions:

M. van Nieuwenhuijzen and B. De Castro developed the study concept and acquired finances. A. Zijlstra conducted the data collection, and M. Ebbers conducted the analyses and drafted the manuscript. M. van Nieuwenhuijzen and B. De Castro supervised the research project, and together with A. Zijlstra revised and edited the manuscript.

Abstract

Children of parents with intellectual disabilities are overrepresented in child protection services (CPS), often have prolonged CPS involvement, are at increased risk of out-of-home placement. Several risk factors play a role in the trajectories of these families in CPS. This exploratory case-file study (N = 110) aimed exploring clusters of risk factors and how these explain CPS trajectories among expectant parents with intellectual disabilities. Latent Class Analysis shows three clusters (1) families headed by parents with intellectual disabilities, (2) single mothers with a limited social network, (3) families with multiple and complex problems. Logistic regression shows a trend that families in clusters 2 and 3 have higher likelihood of escalation to state custody compared to cluster 1. The results show that the population of families with intellectual disabilities in child protection is heterogeneous. Multiple and complex risk profiles, and not the intellectual disabilities itself, are related to child protection trajectories.

Keywords: child protection services, child safety, latent class analysis, parenting, parents with intellectual disabilities, risk factors.

Introduction

Although most parents aim the best for their children, about 25% of children worldwide grow up in situations of child maltreatment (Scheuplein et al., 2023). Even unborn babies can be exposed to unsafety. For example, maternal alcohol use and drug use during pregnancy increase the risk of fetal alcohol syndrome (Popova et al., 2023). Stress, malnutrition, and smoking during pregnancy can be harmful to the child, and increase the risk of preterm birth, lower birth weight (Barker, 2007;

Wadhwa et al., 2009), and also heighten the risk of health problems, psychological, social and mental problems later in life (Norman et al., 2012). Moreover, abusive behavior or domestic violence towards the mother can increase maternal stress and thereby affect the development of the unborn baby (Glover and Capron, 2017). These unsafe circumstances can have long-lasting effects (Black et al., 2017), making it important to protect these unborn babies to overcome unsafe parenting circumstances for medical, economic, psychological, educational, and biological reasons (World Health Organization et al., 2018).

According to Article 1 of the Convention on the Rights of the Child (CRC), the government is responsible for protecting children under the age of 18 (Unicef, 1989). While not legally binding, the preamble of the CRC states that this protection applies both before and after birth. Protection can be provided by voluntary care, such as programs for addicted women, parenting programs, or mental health care. However, if the voluntary measures are insufficient or parents do not want to participate, in certain countries mandatory child protection measures may be issued (see Zijlstra, in press). In the Netherlands, different mandatory child protection measures are used to protect children in unsafe situations, including a family supervision order (FSO) and state custody (Ten Haaf, 2017; Zijlstra et al., in press). However, it is unclear whether unborn children are considered children. To date, the infans-conceptus rule is applied whenever the safety of an unborn child is highly expected to be at risk after birth. However, the infans-conceptus rule is intended for property law matters, not civil rights protection. Nevertheless, Dutch courts do apply this principle in the context of child protection. For example, in cases of maternal substance abuse, domestic violence and avoidance of (prenatal) care (e.g. Raad voor de kinderbescherming v anonymized, 2020; Raad voor de kinderbescherming v anonymized, 2023). Parents of

a child subjected to an FSO retain custody of their child but are obliged to cooperate with the advice of the youth protection professional (Person- and Family Rights, 2021a, 2021b). If an FSO is deemed insufficient to ensure a child's safety, or if the parents have not reached the age of majority (18 years), a child can be subjected to state custody. In that case, parents lose custody of their child because the child's safety cannot be guaranteed within a reasonable period (Person- and Family Rights, 2021a, 2021b). In addition, during an FSO and state custody children can be placed out of home (Person and Family Rights, 2021c). In the Netherlands children can already be subjected to an FSO or state custody before birth.

Mandatory measures to protect unborn and very young children are among the most drastic interventions a government can take. It is therefore crucial to understand when and for whom such intervention are taken. Children of parents with intellectual disabilities are overrepresented in child protection services in high-income countries (e.g., LaLiberte et al., 2024), with a high prevalence for infants (McConnell et al., 2021). Although an intellectual disability in itself is not directly related to unsafe parenting, these families have heightened risks for a cumulation of multiple and complex problems, which increases the risks for unsafe parenting (Feldman and Aunos, 2020; Meppelder et al., 2015). A recent study by Zijlstra et al. (2024) shows that expecting parents with intellectual disabilities in child protection are characterized by a cumulation of risk factors. When they experience risk factors in multiple domains, there is a higher risk for child unsafety at birth. More specifically, more risk factors in the care and family functioning domain are associated with a higher likelihood of out-of-home-placement within six months after birth, and more risk factors in the child, family, and care domain, are associated with an increased risk of child unsafety.

Families with intellectual disabilities vary tremendously, compared to each other, in the nature and constellation of risk factors they face and the strengths they have to overcome them. Understanding this heterogeneity is key for effective (preventive) intervention, as intervention effects are likely to depend on the individual fit of each intervention component with a family's needs (Van Aar et al., 2019). Unfortunately, it is unknown whether clusters of parents can be found based on shared risk factors, and how these clusters are related to child protection trajectories. Knowledge of these clusters may allow us to tailor the intensity and nature of support to their needs and likely trajectories. Therefore, a cluster analysis will be conducted in the current study to investigate which risk factors cluster together in expecting parents with intellectual disabilities in CPS.

In the absence of cluster analyses among families with parents with intellectual disabilities in CPS, several studies exploring clusters of other families in CPS may be relevant. Four earlier studies show the possibility of clustering families into profiles based on risk- and protective factors. The first study clustered families based on risk factors hindering meeting the child's developmental needs and identified five profiles: (1) *parental unavailability*, (2) *dysnormative families*, (3) *child neglect*, (4) *child-specific problems*, and (5) *dysfunctional families* (Goulet et al., 2018). The second study, using cases of neglect substantiated by the child protection services, identified five child maltreatment profiles in cases of child neglect: (1) *difficult children*, (2) *fragilized parents*, (3) *isolated families,* (4) *distressed families*, and (5) *high-need children* (Clément et al., 2020). Another study showed four profiles for children aged 0 to 6 years old, experiencing out-of-home placement, based on risk and protective factors (Calheiros et al., 2022). The first profile includes toddlers, with as risk factors the child's young age and emotional problems, conflict or

aggressive behavior in the parent's history, and housing conditions, and physical health as a protective factor. The second profile was characterized by children living in single-parent families, having few risk factors. The third profile is characterized by a higher rate of alcohol and drug use, worse housing conditions, less parental engagement, and a higher frequency of child maltreatment. In the fourth profile, the prevalence of risk factors exceeds the protective factors. In addition, a study on violence and conflict in multiproblem families identified five profiles not based on quantitative data but on in-depth interviews and literature: (1) *intimate terror*, (2) *family under stress*, (3) *long-term care*, (4) *child behavior & parenting stress,* and (5) *complex conflict divorce* (Steketee et al., 2020).

All the aforementioned clustering studies show the possibility of clustering families in profiles based on their risk accumulation. However, none of the studies applied clustering for the population of parents with intellectual disabilities, and none of them included unborn babies. Therefore, it is unknown how clusters can be made for families with unborn babies, whose parents have intellectual disabilities in child protection. Since these families are a specific group with specific risks and needs, we cannot assume that the profiles from earlier research in families without intellectual disabilities also apply to these (future) parents with intellectual disabilities. Therefore, the current study intends to fill this gap by investigating:

1. What clusters can be identified of expectant parents with intellectual disabilities in child protection who share similar patterns of risk factors from different life domains?
2. How are these clusters related to the child protection trajectories a) out-of-home placement within 6 months after birth, and b) escalation from FSO to state custody?

Method

Sample

To identify clusters of parents and relate them to child protection trajectories, this study used a dataset of Zijlstra et al. (2024) for secondary analyses. The sample included 110 closed casefiles (50.9% girls, 49.1% boys) from children in the Netherlands who had been subject to a CPM before birth (mean age at start = -28 days, *SD* = 29 days), such as a family supervision order (*n* = 103, 93.6%) or state custody (*n* = 7; 6.4%). Of the children with an FSO, 47.3% later escalated to state custody. For these cases only the files before escalation were considered. All mothers in the sample had intellectual disabilities based on the judgment of a professional (*n* = 108), or adaptive functioning (*n* = 2). For 77 mothers the IQ score was reported (*M* = 66, *SD* = 9). The IQ score of fathers was reported only for 27 of them (*M* = 67, *SD* = 11).

Procedure

The procedure for the study of Zijlstra et al. (2024) was approved by the Ethics Review Board of the University of Amsterdam (2021-CDE-1872). This data was collected through casefile examination and consists of reports from youth-care workers of individual children in child protection. For scientific research aiming for quality promotion, examination of casefiles is allowed without active consent from the individuals involved in these casefiles according to the laws and regulations on Child Protection Measures (Data processing, privacy, and consent, 2022). The involved participants' lives were not harmed disproportionately, and the participants could not be traced back in the data. The casefiles consisted of court orders, council reports, internal reports (e.g. assessments of risk and safety, intervention plans), and reports of externally provided care. Casefiles were included when (1) a CPM was assigned before birth,

(2) according to registration details, the child's mother had intellectual disabilities, (3) the casefiles were closed between 2015 and 2019, and (4) the casefiles included a risk and safety assessment or a civil report. For the original study by Zijlstra et al. (2024), an a priori G*Power power analysis was conducted, resulting in a random selection of 110 cases for a power of .90 for their analyses. For the analyses of the current study, this random sample was relatively small, and the results therefore have to be interpreted with caution (Wurprts and Geiser, 2014). The case files were coded and partly double coded by trained researchers, using a coding system (see below) capturing risk factors that were evident in the families from the CPM's start until the age of six months.

Measures

The coding system used to examine the casefiles was based on an ecological overview of risk factors by Bodden and Deković (2016) for families with multiple and complex problems in youth care. This coding system was also used (partly) in a study by Vervoort et al. (2018) and Sterenborg et al. (2023), and was slightly modified for the present specific sample of (unborn) babies. The risk factors were coded as either present or not present in the seven life domains: child, parent, parenting, family functioning, contextual, social, and care. For a description of the clusters see [masked for blind review]. To assess inter-rater reliability, 20% of the sample (n = 22) was randomly assigned to be coded by both researchers. Calculation of Cohen's Kappa (K) for all risk factors showed excellent inter-rater reliability (K = .81; Allen et al., 2014). By using this coding system, risk factors and outcome measures were coded for subsequent use in the analyses.

• **Risk factors**

An operationalization of the risk factors is presented in Table 1. The original dataset included a greater number of risk factors; for the feasibility of the cluster analysis, the number of risk factors was reduced to 22 risk factors. Regarding risk factors, a score of 1 ('present') was given to a risk factor when a description in the casefile matched the coding systems' criteria for one parent. A score of 2 could be given to risk factors where the scores of both parents were combined into one factor. The risk factor regarding the social network, could be scored as 'available' (0), 'small' (1) or 'no' (2). A score of 0 ('not present') was given when no information was available for that risk factor, or when it was explicitly mentioned that this risk factor was not present in this family. To answer the first research question, 22 risk factors within the seven domains were included.

• **Outcomes**

The current study used out-of-home placement and escalation to state custody as separate outcome measures. Out-of-home placement was scored as 'yes' (1) or 'no' (0), depending on whether the child had been placed out of home within six months after birth. When the child returned home within these six months, the 'yes' (1) score remained since the child had experienced out-of-home placement. Escalation to state custody at any time during the child protection measure was scored as 'yes' (1) or 'no' (0), as reported in the casefiles.

Table 1

Operationalization of the Risk Factors per Domain

Domain and variable	***Specification***
Child domain	
Age in days start CPM	The age of the unborn baby at the start of the child protection measure
Emotional abuse	Emotional abuse of the child after birth
Physical abuse before birth	Physical abuse of the child before birth
Neglect	Neglect of the child after birth, including emotional or physical neglect
Domestic violence before birth	Domestic violence of the child before birth, including verbal or physical domestic violence
Domestic violence after birth	domestic violence of the child after birth, including verbal or physical domestic violence after birth
Parent domain	
Psychiatric problems	Psychiatric problems of the parents
Suicidal thoughts or attempts	Suicidal thoughts or attempts of the parents
Substance abuse	Substance abuse by the parents
Prison or justice contacts	Whether parents have been in contact with justice, or have been in prison
Cognitive disabilities father	Cognitive disabilities of the father
Health problems of both parents	Health problems of one or both of the parents
Parental Adverse Childhood Experiences (ACEs)	Amount of ACEs of both mother and father, including physical and emotional neglect and abuse, sexual abuse and (witness of) domestic violence

Scored as 0	Scored as 1	*Scored as 2*
For unborn babies that got a child protection measure before the mean amount of days before birth	For unborn babies that got a child protection measure between the mean amount of days before birth and birth	
No	Yes	
No	Yes	
No	One or both of these forms of neglect	
No	One or both of these forms of domestic violence	
No	One or both of these forms of domestic violence	
None of the parents	One of the parents	Both parents
None of the parents	One or both of the parents	
None of the parents	One of the parents	Both parents
None of the parents	One of the parents	Both parents
No or unknown	Yes	
None of the parents	One or both of the parents	
Below the mean	Above the mean	

Domain and variable	*Specification*
Parenting domain	
Problems with Parenting Skills	Individually filled in for mothers and fathers, including inadequate parenting skills, inconsistent parenting, and an imbalance between parenting capacity versus parenting load
Family functioning domain	
Divorce	Divorce of the parents
Conflicts	Including relational problems between parents, conflicts within the family, and bad cohesion in the family
Contextual domain	
Financial problems	Financial problems, also including unemployment and being under administration
Housing problems	Housing problems of the parents
Social domain	
Limited social network mother	The social network of the mother
Conflicts with neighbors and friends	Conflicts of the parents with neighbors and or friends
Care domain	
Number of care organizations involved before CPM	Number of care organisations involved before the start of the Child Protection Measure
Avoiding care	Whether parents avoid care

Data analysis

All statistical analyses utilized for answering the research questions have been carried out using the statistical program R (v4.3.2; R Core Team, 2023). To answer the first research question, a Latent Class Analysis (LCA) was conducted to identify different clusters of families with parents with intellectual disabilities in child protection services, based

Scored as 0	Scored as 1	*Scored as 2*
Below the mean	Above the mean	
No or unknown	Yes	
Below the mean	Above the mean	
None of the parents	One of the parents	Both parents
None of the parents	One of the parents	Both parents
Available network	Small network	No network
No	Yes	
Below the mean	Above the mean	
No	Yes	

on the variables in the seven domains. For the second research question, two separate logistic regression analyses were conducted to investigate how each of the profiles, found in the LCA, were related to out-of-home placement within six months and escalation from FSO to state custody. In these analyses, out-of-home placement and escalation to state custody were regressed on the risk profiles.

• Latent Class Analysis (LCA)

The R-package poLCA (v1.6.0.1; Drew et al., 2011) was used to find risk-based clusters of families in the LCA. This analysis-method is a probabilistic analysis of unsupervised clustering to determine whether latent, unobserved clusters exist in the data, based on observed categorical variables (Sinha et al., 2021). Using these observed variables, LCA identified clusters of participants in which the variables follow the same pattern. Several models, each with a pre-specified number of clusters were compared with each other. The best model was then chosen based on maximum likelihood estimates, resulting in clusters distinct from each other but homogeneous within themselves (Sinha et al., 2021). A probability was calculated for each individual to belong to each cluster, and each individual was assigned to the highest class probability. The current LCA was exploratory because of the relatively small (N = 110) sample size and could only be used to give first insights, thus the results have to be interpreted with great caution (Sinha et al., 2021). LCA is a 'large sample' method, and according to Wurprts and Geiser (2014) samples < 300 can have less reliable results, and samples < 70 are not feasible.

To find the best-fitting cluster model, the latent class models were fit for models with one to six clusters. Because of the small sample size, respectively, the fit statistics Akaike information criterion (AIC; Akaike, 1973) and Bayesian information criterion (BIC; Schwartz, 1987) were examined to find the model with the lowest AIC and BIC (Sinha et al., 2021). Because of the small sample size, BIC could extract too few clusters, and AIC could outperform BIC, therefore AIC was used for the final solution. A graph of AIC was shown to examine if an elbow effect occured (Sinha et al., 2021). In addition, the model with the lowest Log-likelihood was considered. To avoid finding a local maximum in-

stead of a global maximum of the log-likelihood, each model was run 30 times to find the global maximum likelihood solution instead of local maxima and provided the 'right' parameter estimates (Linzer and Lewis, 2011). Next, the clusters were examined, with the size of the groups as the first indicator (Schreiber, 2017). Models with one relatively small cluster, consisting of < 10% of the sample, were viewed with caution (Sinha et al., 2021). Afterward, the variables loadings for each cluster were examined. For binary variables, the rule of thumb of .75 and higher (vs .25 and lower) was set as a criterion to be notable. In variables with three categories, a rule of thumb of .49 and higher (vs .17 and lower) was set as a criterion for being noteworthy. Lastly, clusters were evaluated relative to the other clusters, to examine whether they differed from the other clusters. To conclude, the clusters were provided with a name.

• **Logistic regression**

The generalized linear model function (glm) from base R was used for the logistic regression independently for out-of-home placement and custody. A likelihood ratio test was used to compare whether a model with clusters is significantly better than an intercept-only model, a significance level of .05 is the criterium. McFadden's pseudo-R^2 was reported for model adequacy. Afterwards, the log of odds was used to compare the different clusters, and an estimate, *z*-value, and *p*-value were reported, with *p*-values < .05 indicating significance. Besides, the estimated odds were used to compare the clusters, provided with a 95%-CI.

Results

Latent Class Analysis (LCA)

To identify clusters of expectant parents with intellectual disabilities in child protection who share similar patterns of risk factors, an LCA was carried out. Descriptive statistics of the variables per domain, used for the LCA, are presented in Table 2. Of the six latent class models that were fit, three models appeared to have a negative degree of freedom, namely the models with four to six clusters, and could unfortunately not be examined (see Table 3). Of the three remaining models, the model with three clusters had the lowest AIC, AIC = 3446.79, and the model with one cluster had the lowest BIC, BIC = 3626.10. Because of the small sample size AIC could outperform BIC (Sinha et al., 2021); therefore, the model with three clusters was chosen as the best-fitting model based on the lowest AIC. The AIC elbow flattened around four clusters (see Figure 1). However, since the model with four clusters had a negative degree of freedom, this could not be used as judgment for our best model. Of the three considered models, the model with three clusters had the lowest log-likelihood (-1637.39). All the above pointed to the three-cluster model as the best model. The model with three clusters consisted of clusters with 41, 50, and 19 families, and did not consist of one cluster with <10% of the sample. All probabilities per variable were examined for each cluster (see Table 4).

Table 2

Descriptive Statistics of the Risk Factors per Domain

Domain and variable	No (%)	Yes (%)	None of the parents (%)	One of the parents (%)
Child domain				
Age in days start CPM				
Emotional abuse	91 (82.7%)	19 (17.3%)		
Physical abuse before birth	49 (44.5%)	61 (55.5%)		
Neglect	63 (57.3%)	47 (42.7%)		
Domestic violence before birth	34 (30.9%)	76 (69.1%)		
Domestic violence after birth	88 (80.0%)	22 (20.0%)		
Parent domain				
Psychiatric problems			39 (35.5%)	44 (40.0%)
Suicidal thoughts or attempts			79 (71.8%)	31 (28.2%)
Substance abuse			38 (34.5%)	45 (40.9%)
Prison or justice contacts			54 (49.1%)	45 (40.9%)
Cognitive disabilities father	59 (53.6%)	51 (46.4%)		
Health problems of both parents	68 (61.8%)	42 (38.2%)		
Parental Adverse Childhood Experiences (ACEs)				
Parenting domain				
Problems with Parenting Skills				
Family functioning domain				
Divorce	69 (62.7%)	41 (37.3%)		
Conflicts				
Contextual domain				
Financial problems			4 (3.6%)	41 (37.3%)
Housing problems			38 (34.5%)	36 (32.7%)
Social domain				
Limited Social network mother				
Conflicts with neighbors and friends	87 (79.1%)	23 (20.9%)		

Both parents (%)	Below the mean (%)	Above the mean (%)	Available (%)	Small (%)	No (%)	Mean (*SD*)
	43 (39.1%)	67 (60.9%)				–27.73 (29.33)
27 (24.5%)						
27 (24.5%)						
11 (10.0%)						
	67 (60.9%)	43 (39.1%)				1.15 (1.04)
	59 (53.6%)	51 (46.4%)				0.87 (1.10)
	37 (33.6%)	73 (66.4%)				1.89 (1.15)
65 (59.1%)						
36 (32.7%)						
			28 (25.5%)	59 (53.6%)	13 (11.8%)	

Domain and variable	No (%)	Yes (%)	None of the parents (%)	One of the parents (%)
Care domain				
Number of care organizations involved before CPM				
Avoiding care	48 (43.6%)	62 (56.4%)		

Table 3

Comparison of Fit Indices in the Six LCA-Models Fitted to the Data

	Log Likelihood	AIC	BIC	Number of full cases	Number of parameters	*df*
1 cluster	−1747.24	3550.49	3626.10	93	28	82
2 clusters	−1680.67	3475.34	3629.27	93	57	53
3 clusters	**−1637.39**	**3446.79**	**3679.03**	**93**	**86**	**24**
4 clusters	−1599.45	3428.90	3739.46	93	115	−5
5 clusters	−1574.26	3436.52	3825.39	93	144	−34
6 clusters	−1546.83	3439.67	3906.85	93	173	−63

Note: The best-fitting model is in bold.

Both parents (%)	Below the mean (%)	Above the mean (%)	Available (%)	Small (%)	No (%)	Mean (*SD*)
	64 (58.2%)	38 (34.5%)				4.14 (2.34)

Figure 1

Elbow Plot for Akaike Information Criterion (AIC)

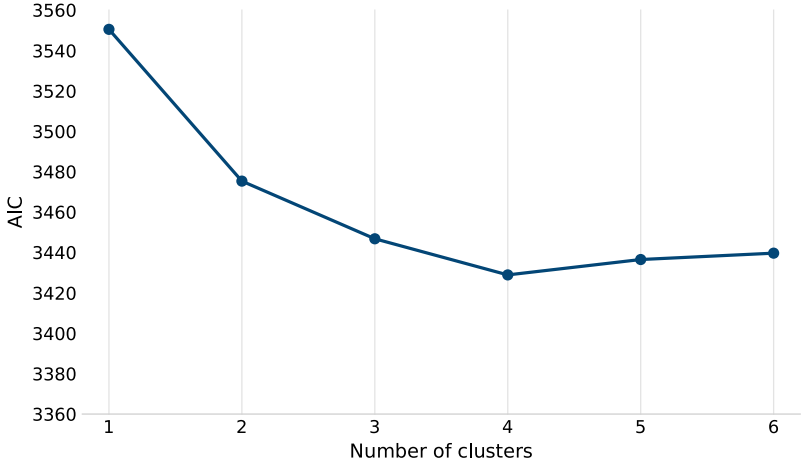


Table 4

Cluster Probabilities per Variable

Variable	Cluster	Probability		
		0	1	2
Child domain				
Age in days start CPM	cluster 1	.30	.70	
	cluster 2	.42	.58	
	cluster 3	.45	.55	
Emotional abuse	cluster 1	**.89**	.11	
	cluster 2	**.79**	.21	
	cluster 3	**.79**	.21	
Physical abuse before birth	cluster 1	**.75**	.25	
	cluster 2	.21	**.79**	
	cluster 3	.29	.71	
Neglect	cluster 1	.56	.44	
	cluster 2	.52	.48	
	cluster 3	.60	.40	
Domestic violence before birth	cluster 1	.49	.51	
	cluster 2	.53	.47	
	cluster 3	.09	**.91**	
Domestic violence after birth	cluster 1	**.88**	.12	
	cluster 2	**.84**	.16	
	cluster 3	.72	.28	
Parent domain				
Psychiatric problems	cluster 1	.72	.18	.10
	cluster 2	.16	**.84**	.00
	cluster 3	.14	.41	.45
Suicidal thoughts or attempts	cluster 1	**.88**	.12	
	cluster 2	.63	.37	
	cluster 3	.62	.38	
Substance abuse	cluster 1	**.72**	.24	.03
	cluster 2	.21	**.68**	.11
	cluster 3	.10	.44	.46
Prison or justice contacts	cluster 1	**.76**	.24	.00
	cluster 2	**.63**	.31	.05
	cluster 3	.23	**.58**	.20

Variable	Cluster	Probability		
		0	1	2
Cognitive disabilities father	cluster 1	.56	.44	
	cluster 2	**.95**	.05	
	cluster 3	.37	.63	
Health problems of both parents	cluster 1	**.76**	.24	
	cluster 2	**.79**	.21	
	cluster 3	.45	.55	
Parental Adverse Childhood Experiences (ACEs)	cluster 1	.74	.26	
	cluster 2	.68	.32	
	cluster 3	.48	.52	
Parenting domain				
Problems with Parenting skills	cluster 1	.61	.39	
	cluster 2	.37	.63	
	cluster 3	.54	.46	
Family functioning domain				
Divorce	cluster 1	**.80**	.20	
	cluster 2	.00	**1.00**	
	cluster 3	.72	.28	
Conflicts	cluster 1	.39	.61	
	cluster 2	.52	.48	
	cluster 3	.22	**.78**	
Contextual domain				
Financial problems	cluster 1	.07	.45	.47
	cluster 2	.00	**1.00**	.00
	cluster 3	.02	.08	**.90**
Housing problems	cluster 1	.38	.36	.26
	cluster 2	.47	.48	.05
	cluster 3	.27	.25	.48
Social domain				
Limited Social Network Mother	cluster 1	.46	.34	.20
	cluster 2	.11	**.89**	.00
	cluster 3	.22	**.66**	.13

Variable	Cluster	Probability		
		0	1	2
Conflicts with neighbors and friends	cluster 1	**.91**	.09	
	cluster 2	**.90**	.10	
	cluster 3	.66	.34	
Care domain				
Number of care organizations involved before CPM	cluster 1	**.79**	.21	
	cluster 2	.72	.28	
	cluster 3	.47	.53	
Avoiding care	cluster 1	.37	.63	
	cluster 2	.47	.53	
	cluster 3	.47	.53	

Note: Probabilities higher than .75 (for variables with two categories) or .49 (for variables with three categories) are in bold.

Cluster 1

Families of two parents with intellectual disabilities

Cluster 1 (N = 41) consisted of families that only scored high on one of the risk factors, and scored low on many other risk factors. Families in this cluster had a high chance that one or both parents had financial problems, including unemployment and being under administration. However, families in this cluster had a relatively small chance of emotional abuse (11%), physical abuse (25%), and domestic violence after birth (12%), variables belonging to the child domain. In the parent domain, they had a relatively small chance of suicidal thoughts or attempts (12%), and health problems of both parents (24%). Besides, they had a small chance of substance abuse from both parents (3%), and prison or justice contact from both parents (0%). In the family functioning

domain, families had a relatively low chance of divorce (20%). Also, these families had less chance of having conflicts with neighbors and friends (9%). Lastly, families in this cluster had a relatively below-average amount of care involved before the child protection measure started (21%). Compared to the other clusters, children in cluster 1 had a higher chance of having a higher age at the start of the CPM (70%), and these families had a higher chance that none of the parents had a psychiatric disorder (72%), relative to the other clusters. They also had a higher chance that the mother had an available social network (46%) compared to clusters 2 and 3. In sum, we can say that families in this cluster seem to have few risk factors in all domains.

Cluster 2
Single mothers with a limited social network

Cluster 2 (N = 19) contained families that tend to score high on some risk factors but low on others. In the child domain, these families had a high chance of physical abuse before birth (79%) but a low risk for emotional abuse (21%), or domestic violence after birth (16%). In the parent domain, families in this cluster had a high chance that one of the parents had psychiatric problems (84%) and that one of the parents used substances (68%). On the other hand, families had a low chance that any of the parents had justice contacts or had been in prison (63%). Parents in this cluster had a low risk for health problems of both parents (21%). Fathers in this cluster had a low chance of having intellectual disabilities (5%). In the family functioning domain, families had a high chance of having a divorce (100%). In the contextual domain, families had a high chance that one of the parents had financial problems, was unemployed, or was under administration (100%), and a low chance that both parents had housing problems (5%). In the social domain, families

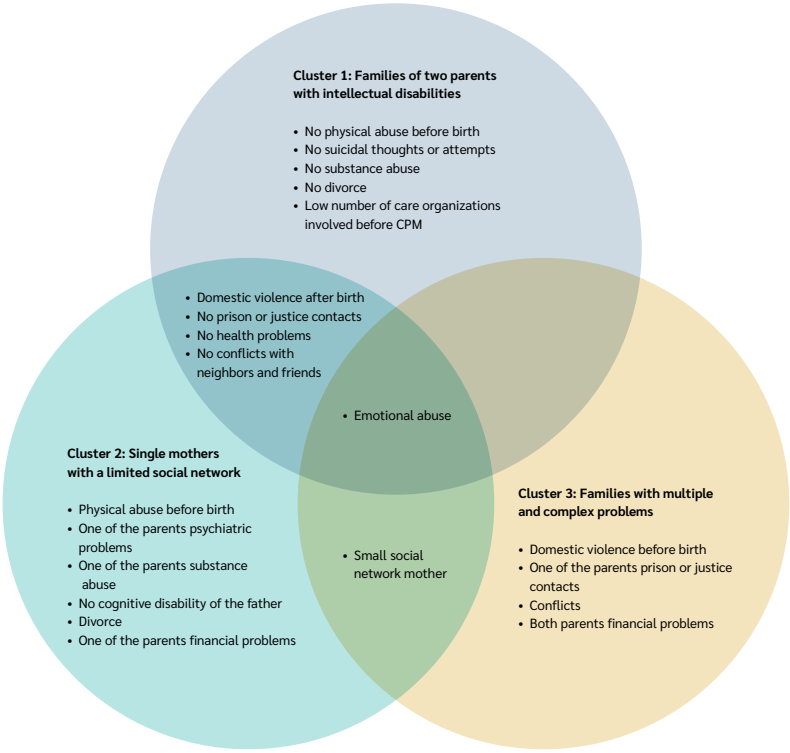
had a low chance of having conflicts with neighbors and friends (10%), but mothers had a higher chance of having a small social network (89%). Compared to clusters 1 and 3, families in cluster 3 had a higher chance of scoring high on a lack of parenting skills (63%). In sum, families in this cluster all went through divorce, most often had mothers with a limited social network, and histories of physical abuse before birth.

Cluster 3
Families with multiple and complex problems

Cluster 3 (N = 50) consisted of parents who tend to score high on many risk factors, compared to a small number of low-risk factors. In the child domain, families had a low chance of emotional abuse (21%) but a high chance of having domestic violence before birth (91%). In the parent domain, parents had a high chance that both parents used substances (90%), and a high chance that one of the parents had justice contacts or had been in prison (58%). In the family functioning domain, families in this cluster had a high chance of having conflicts within the family, including relational problems and bad cohesion (78%). In the contextual domain, families had a high chance that both parents had financial problems, were unemployed, or were under administration (90%). In the social domain, families in cluster 3 had a high chance that mothers had a small social network (66%). Compared to the other clusters, families in cluster 3 had a high chance that both parents had psychiatric problems (45%), both used substances (46%), and had health problems (55%). Lastly, these families had a higher chance of conflicts with neighbors and friends (34%), and had a higher number of care involved before CPM (53%) than the other clusters. In sum, families in this cluster tend to have multiple and complex problems in multipledomains.

Figure 2

Overlap and Differences Between Clusters



Logistic regression

Out-of-home placement

To examine how the clusters found in the LCA were related to out-of-home placement within 6 months after birth, logistic regression was conducted. Of the entire sample 54 children (49.1%) had an out-of-home placement. The predicted probability of having an out-of-home placement for children in cluster 1 was 48.8%, with 20 children in this

cluster having an out-of-home placement. For children in cluster 2, the predicted probability of having an out-of-home placement was 63.2%, with 12 children in this cluster having an out-of-home placement. For children in cluster 3, the predicted probability of having an out-of-home placement was 44.0%, with 22 children in this cluster having an out-of-home placement. A likelihood ratio test showed that allowing for group differences in out-of-home placement, did not significantly fit better than an intercept-only model, χ^2 (2) = 2.04, p = .36, McFadden's pseudo-R^2 = 1.3%. The log of odds also showed no significant differences between any of the clusters (see Table 5).

In conclusion, no significant differences were found between the three clusters when comparing them for out-of-home placement, and a model with groups did not fit the data better than an intercept-only model.

Custody

To examine how the clusters found in the LCA are related to escalation from FSO to state custody, a second logistic regression analysis was conducted. Of the entire sample, for 52 children (47.3%) the FSO escalated to state custody. The predicted probability that the FSO escalated to state custody for children in cluster 1 was 34.2%, with 14 children in this cluster for whom the FSO escalated to state custody. For children in cluster 2, the predicted probability that the FSO escalated to state custody was 57.9%, in this cluster for 11 children the FSO escalated to state custody. For children in cluster 3, the predicted probability that the FSO escalated to state custody was 54.0%, with 27 children in this cluster for whom the FSO escalated to state custody.

Table 5

Log of Odds of Getting an Out-of-home Placement Comparing Different Clusters

	b	*z*	*p*	Estimated odds difference	95% CI
Cluster 2 compared to cluster 1	0.59	1.03	.30	$e^{0.59} = 1.8$	[0.60, 5.71]
Cluster 3 compared to cluster 1	–0.19	–0.46	.65	$e^{-0.19} = 0.83$	[0.36, 1.89]
Cluster 3 compared to cluster 2	–0.78	–1.41	.16	$e^{-0.78} = 0.46$	[0.15, 1.33]

A likelihood ratio test showed that allowing for group differences in custody did not significantly fit better than an intercept-only model, $\chi^2(2) = 4.66$, $p = 0.097$ but a trend effect was seen. McFadden's pseudo-R^2 = 3.1%, which was a small effect accordwing to Cohen (1988). The log of the odds of having custody was almost significantly higher for group 2 and group 3 compared to group 1 (see Table 6). The log of the odds of having custody was not significantly higher for cluster 3 than for cluster 2.

In conclusion, there were no significant differences between the three clusters when comparing them for custody and a model with clusters did not fit the data better than an intercept-only model. However, a trend effect was seen in a difference between cluster 1 and cluster 2 and 3, meaning that children in cluster 2 and 3 may have more chance of getting custody than cluster 1.

Table 6

Log of Odds of Escalation from FSO to Custody Comparing Different Clusters

	b	*z*	*p*	Estimated odds difference	95% CI
Cluster 2 compared to cluster 1	0.98	1.71	.09	$e^{0.98} = 2.65$	[0.88, 8.36]
Cluster 3 compared to cluster 1	0.82	1.88	.06	$e^{0.82} = 2.26$	[0.98, 5.41]
Cluster 3 compared to cluster 2	–0.16	–0.29	.77	$e^{-0.16} = 0.85$	[0.29, 2.47]

Post-hoc analysis

The trend effect found in the logistic regression, showing a difference between escalation to custody between cluster 1 and both clusters 2 and 3 separately, gave reason to further investigate this trend. Because of the relatively small sample size, causing power problems, a post-hoc analysis was conducted to investigate differences in custody between cluster 1 compared to the combination of clusters 2 and 3.

A likelihood ratio test showed that allowing for group differences in custody did significantly fit better than an intercept-only model, χ^2 (1) = 4.58, $p < .05$. McFadden's pseudo-R^2 = 3.0%, which was a small effect according to Cohen (1988). The log of the odds of having custody was significantly higher for the combination of groups 2 and 3, compared to group 1, $b = 0.86$, $z = 2.11$, $p < .05$. The estimated odds difference was $e^{0.86} = 2.36$, 95% CI [1.07, 5.37].

The post-hoc analysis showed a difference between cluster 1 and the combination of cluster 2 and 3, when comparing them for custody. This means that children in clusters 2 and 3 have a greater chance of being subjected to state custody than children in cluster 1. This gives reason to

assume that the difference between cluster 1 compared to clusters 2 and 3 separately is a power issue due to the small sample size.

Discussion

This study aimed to identify clusters of expectant parents with intellectual disabilities within the child protection system that shared similar patterns of risk factors and to examine how each of these clusters was related to the child protection trajectories of out-of-home placement within 6 months after birth and escalation to state custody. Three clusters were identified, consisting of a cluster with both parents having an intellectual disability, a cluster with single mothers with a limited social network and a third cluster consisting of families with multiple and complex problems. The three clusters had similar risks of FSO, but the risk of escalation to custody seemed lower for the cluster of single mothers with a limited social network than for the other families. The current study shows that the population of parents with intellectual disabilities in child protection is heterogeneous. Each of the clusters faces different risk factors and diverse challenges. Besides, the study gives first insights that the clusters of families differ in whether their FSO escalates to state custody.

The results of the cluster analysis show three different clusters: (1) *families headed by parents with intellectual disabilities*, having relatively few risk factors, with about half of the fathers also having intellectual disabilities; (2) *single mothers with a limited social network*, experiencing physical abuse before birth, having psychiatric problems, financial problems, a small social network, and relatively few parenting skills; and (3) *families with multiple and complex problems*, in which families score high on a great number of risk factors. The cluster with

single mothers with a limited social network (cluster 2) is in line with a study by Calheiros et al. (2022), that also found a cluster with single-parent families in a population of families and young children being removed from their families. However, in contrast to the current study, the cluster with single-parent families in a study by Calheiros et al. (2022) was characterized by fewer risk factors than the many risk factors that were found in the current cluster with single mothers (cluster 2). This could be caused by the intellectual disability of the mothers in the current study, who face more risk factors than other mothers. The cluster with families having multiple and complex problems (cluster 3) is in line with earlier studies too (Calheiros et al., 2022; Goulet et al., 2018), which also found one cluster with an extremely high amount of risk factors for children's development and well-being.

Although the heterogeneous clusters differed in the number of risk factors, the logistic regression shows no significant evidence of a difference between clusters in the likelihood of out-of-home placement. In contrast with Perlman and Fantuzzo (2013) showing that a heightened risk for maltreatment increases the risk for out-of-home placement, the current results show no difference in out-of-home placement. A possible explanation could be that the current study only looks at out-of-home placement up to 6 months after birth and that an out-of-home placement still occurs after these six months. Possibly, the clusters with families with more risk factors (cluster 3) would have a higher chance for out-of-home placement if families had been followed for a longer period of time.

The results of the logistic regression show a trend that families with multiple and complex problems (cluster 3) and single mothers with a limited social network (cluster 2) appear to have a higher likelihood of

escalation to state custody than families headed by two parents with intellectual disabilities and few risks (cluster 1). The post-hoc analysis shows that there is a power problem when comparing cluster 1 with cluster 2 and 3 separately. This post-hoc analysis shows that cluster 1 does significantly differ from cluster 2 and 3 combined. The families in cluster 1 are more likely to be intact families, with fewer risk factors. Half of the families in this cluster are formed by two parents with intellectual disabilities. Besides, compared to the other clusters, the mothers in these families have an available social network. This provides preliminary indications that the intact families, with about half of the fathers also having intellectual disabilities, can raise their children good enough with an FSO or other support from professionals or their social networks, and that for them the FSO less often seems to escalate to state custody. Parents with intellectual disabilities are repeatedly stigmatized for not being able to raise children (Franklin et al., 2022; Theodore et al., 2018). However, the trend this study found, is in line with earlier research, showing that not the intellectual disability itself but the risk factors are related to parenting performance (e.g. Feldman and Aunos, 2020).

When interpreting the results, several strengths and limitations should be considered. A clear strength is the sample of the current study, which is unique, consisting of families with a parent with intellectual disabilities whose child was subjected to child protection services before birth. To the authors' knowledge, this is the first study to investigate clusters and how these are related to child protection trajectories in this particular sample. Although this is a strength, this unique sample also makes the findings less generalizable to other populations. Another strength of this study is the comparison of clusters for out-of-home placement or escalation from FSO to state custody, which other studies have not yet investigated.

This study also has several limitations. One of the limitations is the examination of out-of-home placement only till 6 months after birth. Possibly, some children have been placed out-of-home after these 6 months. It would have been informative to get insights into the out-of-home placement at a later stage and whether that would impact the difference between clusters in out-of-home placement. Furthermore, this study only assessed casefiles that were closed between 2015 and 2019. It would be interesting to investigate files with families who returned to child protection at a later stage, to follow these children and investigate their risk- and protecting factors longitudinally. Possibly, their situations are the reason that child protection services are again involved, and investigating their files could give insight in their need for support. Another limitation of the study is that we could not assess family strengths and resources in the primarily problem-oriented case files, except for the absence of risk factors. Thus, apart from the absence of risk factors, we could not examine the value of other protective and promotive factors on cluster composition, FSO, and custody. This is unfortunate, because building on family resources and protective factors may be key to effective support. More systematic attention to these factors may be key to improving case files, judicial decision making, and future research. The most prominent limitation of this study is the small sample size. For both LCA and logistic regression a larger sample is preferred for more reliable results. Therefore, results have to be interpreted with caution, and this analysis should only be interpreted as an exploratory study to find possible clusters. Possibly, results of the LCA may change in a larger sample or give a different amount of clusters, or logistic regression may show different results for out-of-home placement and escalation from FSO to state custody. As a result of the small sample size, the number of the variables had to be reduced, and information was lost because variables were aggregated. Therefore, risk factors could not be examined

separately and conclusions could not be drawn for each risk factor separately.

Although the sample size is relatively small, this study contributes to scientific literature about families with intellectual disabilities in child protection. Most importantly, this is the first study to find clusters of families in the population of expectant parents with intellectual disabilities in child protection services before birth, and shows that this population is not homogenous. Instead, this study shows a heterogeneous population, with different types of families, each with their own risk factors and urgency for support. This study is also the first to examine clusters of parents expecting a child. Other studies have not yet investigated this for families with children before birth. Moreover, this study is the first to examine for each of the clusters how they are related to child protection measures. These findings support the scientific field, especially the field of child protection and (expectant) parents with intellectual disabilities.

Importantly, the results of the current study have several implications for professionals in child protection working with families with children whose parents have intellectual disabilities. It is important to mention once more that the current study focused on mothers with intellectual disabilities, and that the clusters cannot be generalized to families in child protection in general. When child protection services become involved in families headed by parents with intellectual disabilities, immediate urgency should be given to families with multiple and complex problems. These families need extra support to reduce the risk factors and the likelihood that the FSO escalates to state custody, for instance using programs as described in the scoping review of Zijlstra et al. (2023), such as 'Mellow Futures' (Tarleton and Heslop, 2021) for pregnant mothers,

'Home-Based Parent Training Program' (Feldman et al., 1992a), or STARS (Keltner et al., 1995). Also 'Safe Start' (Zijlstra et al., 2024, manuscript submitted) or the Dutch program HoldOn (Lever and Ivanišević, 2022) can be suggested for support for parents with intellectual disabilities. For families with multiple and complex problems, professionals should focus on reducing the large number of risk factors and strengthening potential protective factors. For single-parent families with a limited social network, it would be recommended to use programs to enlarge the social network with neighbors, parents from school, or to stimulate them to start (volunteer) work, in turn improving the resilience of people with intellectual disabilities (Scheffers et al., 2020; 2023). For families in cluster 1, having fewer risk factors, in which parents tend to both have intellectual disabilities and are still in a relationship with each other, the results imply that these families manage parenting with an FSO or other help, or at least seem to have less chance that the FSO escalates to state custody. Further research and support should be focused on preventing these families from entering child protection services, to ensure that voluntary support or other support is sufficient for these families.

The current research findings show the importance of future research to investigate further clusters of families with intellectual disabilities in child protection. First of all, it is important to investigate whether the results of this exploratory study can be replicated in a longer prospective longitudinal study with a larger sample. A longer study, with more frequent measurement occasions may clarify whether changes in risk patterns over time actually predict changes in out-of-home placement and escalation to state custody. Future research should use a longitudinal design to study the development of the child protection trajectories of children with parents who have intellectual disabilities, for

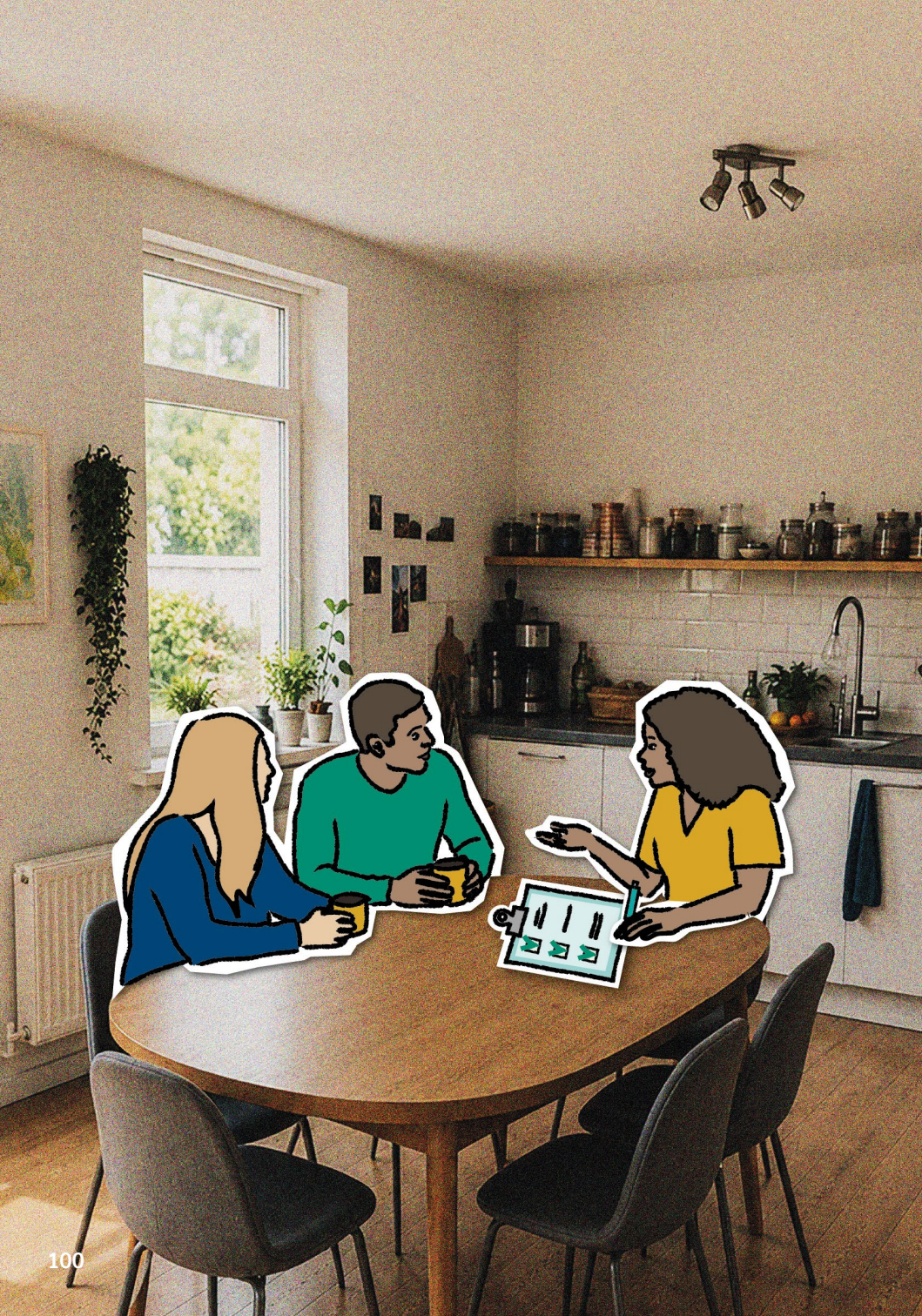
example, in the length of the trajectories or whether the families return into care after a casefile has been closed. In this, it would also be interesting to use qualitative measures to investigate the experiences of parents and children themselves, and the professionals working with the families. With a larger sample, it will also be possible to include more risk factors to examine which clusters of families face which particular risk factors more thoroughly. Related to this point, future research should examine the role of the social network of families, which can be of great value in supporting the family. This may be particularly relevant for families in Cluster 1, where the highly prevalent physical abuse and divorce may have disrupted previous social networks, and support in building a new social network may be crucial.

The current study focused on expectant families with intellectual disabilities already in child protection services. Further research could also focus on preventing the need for a child protection measure or FSO. International comparative research suggests that in some countries strengthening voluntary support and helping families earlier might prevent the need for FSO's considerably (Zijlstra et al., 2025). When more research is conducted, this will impact the knowledge and support for (expectant) parents with intellectual disabilities.

Conclusion

Expectant families with intellectual disabilities in child protection services experience a multitude of risk factors, that vary between families. The present study shows that the population of families with intellectual disabilities in child protection is heterogeneous, with three main clusters of risk factors: (1) *families headed by parents with intellectual disabilities*, (2) *single mothers with a limited social network*, and (3) *families with multiple and complex problems*. The results show that

multiple and complex risk profiles, and not the intellectual disabilities itself, are related to child protection trajectories. Since this study is exploratory, further investigation and clustering of these families is needed to replicate these results and to further improve the support of the families with intellectual disabilities in child protection, with the most important purpose of reducing the risk of maltreatment.





Chapter 5

The first 1001 days: A scoping review of parenting interventions strengthening good enough parenting in parents with intellectual disabilities

Chapter 5 was published as:

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Author contributions:

M. van Nieuwenhuijzen and B. De Castro developed the study concept and acquired finances. A. Zijlstra and D. H. J. Joosten conducted the data collection and the analyses. A. Zijlstra drafted the manuscript. M. van Nieuwenhuijzen and B. De Castro supervised the research project, and together with D. H. J. Joosten revised and edited the manuscript.

Abstract

There are concerns about parents' parenting skills with intellectual disabilities. However, it is reported that parents with intellectual disabilities show good enough parenting if they are supported effectively and in line with their needs. This scoping review identifies and critically evaluates preventive interventions for parents with intellectual disabilities and a cumulation of multiple and complex problems that aim to prepare them for good enough parenting. Six interventions were identified, with preliminary to strong indications of effectiveness. Although none of the interventions focused on all conditions of good enough parenting and only one intervention incorporated all seven key elements to effectively work with parents with intellectual disabilities, the limited evidence on the effectiveness of these interventions suggests that significant and societally relevant effects on parents' knowledge and skills can be attained. This suggests that more comprehensive early preventive interventions with rigorous evaluations can have a significant impact.

Keywords: parents with intellectual disabilities, preventive parenting interventions, supporting parents, safeguarding children, 1001 days movement.

Introduction

Concerns have been reported about whether parents with mild to borderline intellectual disabilities (hereinafter: intellectual disabilities), who have significant limitations in both intellectual functioning and adaptive behaviour (Schalock et al., 2021), will become good enough parents (Llewellyn and Hindmarsh, 2015; Tarleton and Ward, 2007). In general, children of parents with intellectual disabilities are at greater

risk of developmental problems (e.g., Emerson and Brigham, 2014; Llewellyn and Hindmarsh, 2015; Schuengel et al., 2017), and of becoming victims of neglect and abuse (e.g., Slayter and Jensen, 2019; Wickstrom et al., 2017). Consequently, these children are overrepresented in child protection services (e.g., McConnell et al., 2021; Powell, 2016). Parents with intellectual disabilities are considered one of the most vulnerable groups of parents (Wilson et al., 2013), given the high rates of out-home-placements within these families and the increased risk of losing custody (e.g., Booth et al., 2005; McConnell et al., 2021). Besides these consequences for children and families, there are also significant societal consequences. For example, the social cost of youth care is estimated at €100,000 per child for the entire period of youth care (Romeo et al., 2006), and more recent figures show that an out-of-home placement under a family supervision order in the Netherlands costs an average of €17,000 per child per year (Harder et al., 2020).

The increased risks of unsafe parenting circumstances for children of parents with intellectual disabilities can reflect the multiple and complex problems that these parents often face. As a group, parents with intellectual disabilities relatively often experience multiple and complex problems, such as being a young and single parent, living in poverty, having poor mental health, having a lack of social supportive networks (e.g., Aunos et al., 2008; Meppelder et al., 2015; Powell et al., 2017; Wade et al., 2008), and having children with special needs, due to their increased risk of inherited intellectual disabilities (McGaw et al., 2010). A cumulation of these problems is already seen during pregnancy, which impacts the child's safety once the child is born (Zijlstra et al., 2023). For example, when a child is exposed to violence during pregnancy or when financial or housing problems ensue, the parents' stress levels increase. This can lead to inadequate parenting and negative family functioning,

and ultimately to problems in the children's psychosocial development, such as problems in mental health, school dropout, addiction, and delinquency (Hindmarsh et al., 2017; Murray et al., 2010). Thus, rather than the limited cognitive abilities of parents with intellectual disabilities directly leading to inadequate parenting, it is especially a cumulation of personal and environmental factors that leads to inadequate parenting (Zijlstra et al., 2023). In conclusion, a cumulation of problems in combination with intellectual disabilities tends to spark a vicious cycle of increasing problems and decreasing strengths that jeopardize the prospects for a new-born child to grow up in a safe environment.

There is, however, a growing body of research that shows that many parents with intellectual disabilities are capable of good enough parenting, as long as they are adequately supported in line with their needs (Collings and Llewlynn, 2012; IASSID, 2008; Koolen et al., 2020). The term 'good enough parenting' means a stable, carin°g, and loving 'parenting' of the child, which enables the child to develop good enough (Winnicott 1965 in Hoghughi and Speight, 1998). The term implies that a parent does not have to be perfect in raising his or her baby. It is considered neither realistic nor necessary to expect perfection from parents, and such expectancies would undermine the parenting skills of the majority of parents who do actually meet their children's needs sufficiently (Winnicott 1965 in Hoghughi and Speight, 1998). In line with the 'Best Interest of the Child Model', fourteen conditions have been suggested by Zijlstra (2012) that need to be met for children to develop optimally (see Table 1).

Table 1

Fourteen conditions of good enough parenting from Zijlstra (2012), p.23-37.s

Condition	Definition
1. Adequate physical care	Adequate physical care refers to the care for the child's health and physical well-being by parents or care-providers. They offer the child a place to live, clothing to wear, enough food to eat and (some) personal belongings. There is a family income to provide for all this. In addition, the parents or care-providers are free of worries about providing for the child's physical well-being.
2. Safe direct environment	A safe direct physical environment offers the child physical protection. This implies the absence of physical danger in the house or neighbourhood in which the child lives. There are no toxics or other threats in the house or neighbourhood. The child is not threatened by abuse of any kind.
3. Affective atmosphere	An affective atmosphere implies that the parents or care-providers of the child offer the child emotional protection, support and understanding. There are bonds of attachment between the parent(s) or care-giver(s) and the child. There is a relationship of mutual affection.
4. Supportive, flexible childrearing structure	A supportive, flexible childrearing structure encompasses several aspects like: • enough daily routine in the child's life; • encouragement, stimulation, and instruction to the child and the requirement of realistic demands; • rules, limits, instructions, and insight into the arguments for these rules, limits, and instructions; • control of the child's behaviour; • enough space for the child's own wishes and thoughts, enough freedom to experiment and to negotiate over what is important to the child; • no more responsibilities than the child is capable of handling (in this way the child learns the consequences of his behaviour within the limits which the parents or care-providers have set).
5. Adequate examples by the parent	The parents or care-providers offer the child the opportunity to incorporate their behaviour, values and cultural norms that are important, now and in the future.
6. Interest	The parents or care-providers show interest in the activities and interests of the child and in his perception of the world.
7. Continuity in upbringing conditions, future perspective	The parents or care-providers care for the child and bring the child up in a way that attachment bonds develop. Basic trust is to be continued by the availability of the parents or care-providers to the child. The child experiences a future perspective.

Condition	Definition
8. Safe wider physical environment	The neighbourhood the child grows up in is safe, as well as the society the child lives in. Criminality, (civil) wars, natural disasters, infectious diseases etc. do not threaten the development of the child.
9. Respect	The needs, wishes, feelings and desires of the child are taken seriously by the child's environment and the society the child lives in. There is no discrimination because of background, race or religion.
10. Social network	The child and his family have various sources of support in their environment upon which they can depend.
11. Education	The child receives a suitable education and has the opportunity to develop his personality and talents (e.g. sport or music).
12. Contact with peers	The child has opportunities to have contacts with other children in various situations suitable to his perception of the world and developmental age.
13. Adequate examples in society	The child is in contact with children and adults who are examples for current and future behaviour and who mediate the adaptation of important societal values and norms.
14. Stability in life circumstances, future perspective	The environment in which the child is brought up does not change suddenly and unexpectedly. There is continuity in life circumstances. Significant changes are prepared for and made comprehendible for the child. Persons with whom the child can identify and sources of support are constantly available to the child, as well as the possibility of developing relationships by means of a common language. Society offers the child opportunities and a future perspective.

Good enough parenting, therefore, needs to be assessed from an ecological perspective, in which it is assumed that many people and circumstances interact and influence a child's development (e.g., the interplay between children and their partners, home and community environments, and family and human service systems) (Choate and Engstrom, 2014; IASSID, 2008). From that perspective, a good enough parent also accepts their limitations and is willing to accept help and support (Choate and Engstrom, 2014).

Theoretically, effective key elements in parenting interventions for parents with intellectual disabilities are well documented. First, as contex-

tual factors can affect parenting skills and interventional outcomes, interventions must pay attention to the context and the multiple and complex problems these families face, so that stress factors can be eliminated and parents will be more likely to accept further help (Hanson et al., 2023; Koolen et al., 2020; Meppelder et al., 2015; Mildon et al., 2008; Milot et al., 2016). Second, it seems important to intervene early, even during pregnancy, to shift away from a crisis-driven model to a more preventive model (e.g., Dodge, 2019; O'Keeffe and O'Hara, 2008; Stewart and MacIntyre, 2017). Third, to promote a working alliance, the attitude and approach of the professionals need to be supportive and tailored to the needs of parents with intellectual disabilities (Augsberger et al., 2021; Hanson et al., 2023; Koolen et al., 2020) to increase parents' trust in support and make it more likely that parents will seek and accept help (Meppelder et al., 2014; Willems et al., 2007). Fourth, the professionals should have knowledge of the children's rights to safety (UNICEF, 1989), the rights of the parents with intellectual disabilities to raise a child, and the government's duty to provide support to these families (Hanson et al., 2023; United Nations, 2006). Fifth, interventions must be skill-focused and use behavioural teaching strategies, such as modelling, feedback, praise or tangible reinforcement, and task analysis (Feldman, 1994, as confirmed in Feldman and Tahir, 2016). Sixth, interventions must be home-based (Aunos and Pacheco, 2021; Feldman, 1994), long-term, and intensive (Koolen et al., 2020). Finally, interventions must be in partnership with the family and the informal network of the family in order to increase the resilience of the families (Atkin and Stenfert Kroese, 2021; Scheffers et al., 2020).

However, empirically, little is known about the actual effects of such interventions. Although a wide range of *preventive* parenting interventions is available, parents with intellectual disabilities are generally explicitly

excluded from these interventions, both in research and in practice (Glazemakers and Deboutte, 2013; IASSID, 2008), as these general parenting interventions are often not considered appropriate for them. Unfortunately, parenting interventions specifically for parents with intellectual disabilities are scarce (Coren et al., 2018; Hanson et al., 2023). Moreover, previous reviews of the few studies on parenting training for parents with intellectual disabilities (in chronological order: Feldman, 1994; Wade et al., 2008; Coren et al., 2011; Wilson et al., 2013; Knowles et al., 2015; Coren et al., 2018) emphasized that the evidence concerning interventions for this group was too weak to draw strong conclusions about their effects. On the one hand, the studies included in these reviews were hardly comparable: they focused on a variety of skills and differed in content, techniques, and duration (Knowles et al., 2015; Coren et al., 2018). On the other hand, the reviews did not specifically consider the key elements and the effectiveness of preventive parenting interventions, including interventions during pregnancy, whereas, especially for new-borns, specific treatment elements play a key role in supporting parents with intellectual disabilities to provide good enough parenting and prevent unsafe circumstances. Additionally, none of the reviews considered the suitability of interventions for parents with intellectual disabilities *and* a cumulation of risk factors leading to multiple and complex problems, while it is seen that this is often the case within these families.

With the present scoping review we address these issues by aiming to identify and critically evaluate preventive interventions from pregnancy up to the first 1001 days for parents with intellectual disabilities *and* a cumulation of multiple and complex problems. The 'first 1000 days', counting from conception to a child's second birthday, are widely recognized as a crucial developmental period that sets the foundation for a

child's future well-being (Black et al., 2017; Richter et al., 2017). In this period, the child's brain and cognition develop exceptionally rapidly. While risk factors that emerge during this period can have a significant impact on long-term development, it also provides a critical window of opportunity for interventions that can have a lasting impact on their development (World Health Organization et al., 2018). As parents with intellectual disabilities often experience a cumulation of multiple and complex problems in the first 1000 days, the current research examined:

1. Which preventive interventions during pregnancy and the first 1001 days have been studied for parents with intellectual disabilities *and* a cumulation of multiple and complex problems to prepare them for good enough parenthood?
2. What are the effects of these interventions on good enough parenting?
3. Which key elements have been incorporated into these interventions?

Method

Protocol and registration

The method of this scoping review was based on the scoping review approach proposed by Arksey and O'Malley (2005) and reported in line with the Prisma standards (Page et al., 2021). The protocol has been published on Open Science Framework (https://osf.io/s4z92), before data charting was finished on February 22, 2023.

Eligibility criteria

This review included English language empirical studies that used any design to assess the effectiveness of a preventive intervention (starting

in the period of pregnancy up to the first 1001 days) for parents with intellectual disabilities *and* a cumulation of multiple and complex problems published between 1990-2023. The interventions had to focus on one or more components of good enough parenting. No restrictions were placed on study quality or type of design for assessing the effectiveness of an intervention. Papers were excluded if they described a child-focused intervention that did not involve parent training focused on good enough parenting or interventions for children of parents with intellectual disabilities living in foster care. Reviews, meta-analyses, and book chapters were also excluded from the review.

Search strategy

A literature search was carried out in Web of Science, PsycInfo, and Medline databases, using keywords and their synonyms related to the population (e.g., "parents", "intellectual disab*"), to the intervention period (e.g., "neonatal birth", "infan*"), and intervention (e.g., "parent training", "family intervention") (see the protocol (https://osf.io/s4z92) for the full search strategy). Secondary searches were conducted on references of included papers and relevant reviews and meta-analyses. The 396 identified papers were screened double-blind against the eligibility criteria by two reviewers (AZ and DJ) on title and abstract. Disagreements were resolved by consensus. This procedure resulted in 46 candidate papers. Candidate papers were read in full text and considered for inclusion by one of the two reviewers (AZ or DJ), based on the eligibility criteria. The reviewers double-blindly double-coded 20% of the papers to determine if the paper should be included. Disagreements were resolved by consensus. Eventually, 6 papers met the eligibility criteria. The flowchart is presented in Figure 1.

Data-charting process

To give an overview of which preventive interventions during pregnancy and the first 1001 days have been studied for parents with intellectual disabilities *and* a cumulation of multiple and complex problems to prepare them for good enough parenthood, papers were coded on publication details (e.g., first author, year of publication, country), specifics of the intervention (e.g., target population, focus, start, duration, intensity, training procedure, and location of the intervention), and characteristics of the study (e.g., research design, participants).

Subsequently, to summarize and to give a critical appraisal of the intervention effects on good enough parenting, papers were coded on effects related to the fourteen conditions of good enough parenting (as presented in Table 1). Study designs were critically evaluated against the Standards of Evidence of Prevention Research (Gottfredson et al., 2015). These standards define three stages of research: efficacy, effectiveness, and scale-up (Gottfredson et al., 2015).

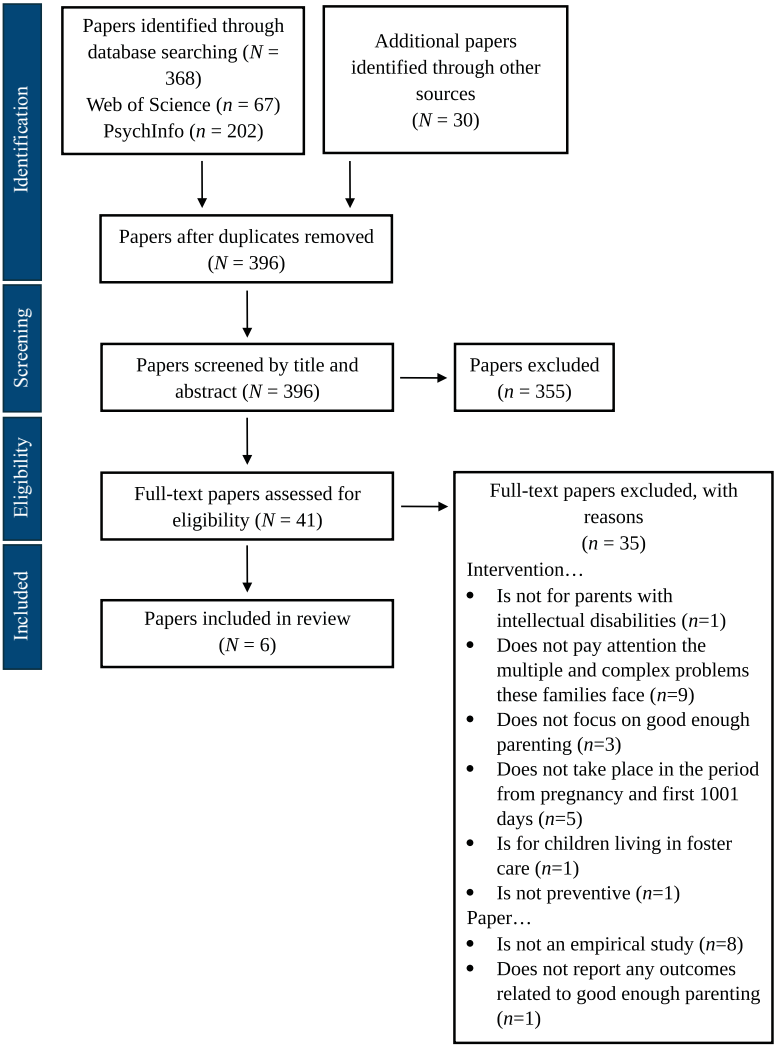
Each stage has its own standards, but the standards are cumulative. Thus, the standards for efficacy are also required for the next stages. Therefore, we first analysed the studies by the efficacy standards, and if they met all standards, we moved on to the following stages. To indicate the strength of the evidence, four different levels of effectiveness have been considered in line with the criteria of Gottfredson et al., (2015): (1) a 'preliminary first indication of effectiveness' is indicated when a study using at least a control group or baseline control examined the effectiveness of the intervention; (2) a 'clear first indication of effectiveness' is indicated when a study with a randomized controlled trial design with severe limitations or a quasi-experimental study examined the effectiveness of the intervention; (3) a 'strong indication of effectiveness' is

indicated when a study with a strong research design (e.g., randomized controlled trial) without severe limitations has examined the effectiveness of the intervention; (4) 'effective' is indicated when multiple studies with strong research designs (e.g., randomized controlled trials) have examined the effectiveness of the intervention.

Finally, to investigate which key elements have been incorporated into these interventions, the interventions were scored on the seven effective key elements in parenting interventions for parents with intellectual disabilities (e.g., interventions must be skill-focused and use behavioural teaching strategies; interventions must be in partnership with the family and the informal network of the family). The data chart form is presented in our protocol (https://osf.io/s4z92).

Figure 1

Flowchart of Included and Excluded Papers



Results

Table 2 summarizes the descriptives of the studies evaluating preventive interventions for parents with intellectual disabilities *and* a cumulation of multiple and complex problems to prepare them for good enough parenting published since 1990, grouped by intervention delivery mode: home-based, and home-based and group-based. For each individual intervention, it provides information on the main focus, the training procedure, and its effects on good enough parenting. In this section, we provide a critical appraisal of each intervention study and its effects on good enough parenting against the Standards of Evidence of Prevention Research (Gottfredson et al., 2015), followed by an evaluation of the incorporated key elements in the interventions.

Home-based interventions

Four preventive home-based interventions for parents with intellectual disabilities *and* a cumulation of multiple and complex problems preparing them for good enough parenthood were identified: the 'Home Based Parent Training Program', the 'Child-care Training Package', the 'Home-based Early Intervention', and the 'Intensive Home-based Parenting Program with a Contextual Fit'.

The 'Home-based Parent Training Program' is focused on teaching basic new-born-, infant-, and child-care skills (e.g., diapering, bathing, and safety) to mothers who are "mentally retarded" (Feldman et al., 1992a: page 16), whose babies (aged 1-23 months) were at risk of child neglect according to social services and child protection agencies. In addition, the intervention also offered advice and support on other issues raised by the mother (e.g., finding a new apartment) (Feldman et al., 1992a). The effectiveness was evaluated in a study by Feldman and

colleagues (1992a), using a repeated measure between-group experimental design, in which 22 mothers with intellectual disabilities (mean IQ: 71.6) were compared to 12 mothers without intellectual disabilities.

The mothers with intellectual disabilities were randomly assigned to the intervention group or the waitlist control group, making it a randomized controlled design (RCT) with three groups: intervention group, waitlist intervention group, and control group (without intellectual disabilities). There were significant improvements in parenting behaviour and knowledge of providing adequate physical care. Mothers with intellectual disabilities learned all necessary child-care skills taught in the training (e.g., bathing, feeding) to levels of correct performance seen in a comparison group without intellectual disabilities. Improvements were maintained for up to 76 weeks, although it should be mentioned that there was substantial variability in the duration of the follow-up period (2 to 76 weeks) (Feldman et al., 1992a).

This study indicates a strong indication of the effectiveness of the 'Home-Based Parent Program' in improving parents' knowledge and skills of adequate physical care, a safe direct environment for the child, and stability in life circumstances is indicated. This study is an RCT with three groups and with a follow-up period. However, the results should be interpreted with some caution. In particular, the duration of the follow-up period varied which makes the conclusions about maintenance unclear. Moreover, the parents involved in this study were already in contact with social services and/or child protection agencies because of concerns about the parent's cognitive abilities in relation to child neglect. This group might, therefore, not be representative of all parents with intellectual disabilities *and* a cumulation of multiple and complex problems.

Also, a small sample with only one measurement at the pretest, post-test, and follow-up was used, which limits to test the reliability of the findings.

The 'Child-care Training Package' is an intervention focused on teaching basic child-care skills (e.g., bathing, diapering) to mothers with an IQ less than 80 whose young children were at risk for or experiencing neglect, reported by a referrer (e.g., advocate, public health nurse or child welfare worker) (Feldman et al., 1992b). The intervention also addressed other issues raised by the mother (e.g., family issues). The effectiveness of the program was evaluated using a multiple baseline design across skills and across mothers with intellectual disabilities (mean IQ: 74) (Feldman et al., 1992b). There were significant improvements in child-care skills after training, with correct performance of child-care skills increasing from 58% at baseline to 90% in training. Performance was maintained for 91% at follow-up at a mean of 32 weeks and 100% for the safety steps (Feldman et al., 1992b).

This study indicates a preliminary first indication of the effectiveness of the 'Child-care Training Package' in improving parents' knowledge and skills of adequate physical care, providing a safe direct environment for the child, and stability in life circumstances in light of the considerable limitations related to the study design. A single-case experimental design with a small sample size was used, in which there was significant variability between cases in baseline probes. Consequently, it was not possible to have multiple overlapping baseline measurements within and between participants and skills, which made it impossible to have a (complete) baseline comparison period. The pretest-posttest results are therefore hard to interpret and should be interpreted with caution.

'The Public Health Nurse Family Home Visiting' is an intervention for first-time, low-income, high-risk pregnant women or new mothers, preparing them to be a parent, with a focus on a healthier pregnancy and birth, learning how to keep children healthy and safe, work on personal and family goals, and connect to programs within their community (Monsen et al., 2011). Although the intervention was not specifically designed for parents with intellectual disabilities, these parents are represented within the target group (Monsen et al., 2011). The feasibility of this intervention for parents with intellectual disabilities was evaluated in a study by Monsen et al. (2011). Based on a secondary analysis of data from clinical documentation, the intervention and outcomes were compared for mothers with intellectual disabilities (based on 'the cognition problem', see next paragraph) and a matched cohort comparison group without intellectual disabilities. At the start of the intervention, mothers with intellectual disabilities experienced more often problems within their environment/context (e.g., problems with income or communication with community resources). After the intervention, mothers with intellectual disabilities significantly improved for 7 of 21 problems, versus 10 of 21 problems for mothers without intellectual disabilities, with improvements in caretaking/parenting knowledge and for contextual factors (e.g., income status and knowledge on substance use) for both groups. There were no significant between-group differences in the amount of improvement, which implies that both groups benefit equally from the intervention (Monsen et al., 2011).

A preliminary first indication of the feasibility and effectiveness of the 'Public Health Nurse Family Home Visiting Program' for parents with intellectual disabilities to improve their caretaking/parenting knowledge and stability in life circumstances is indicated, given the severe limitations related to the study design of Monsen et al. (2011).

It was a pretest-posttest design in which a control group was missing. Moreover, no correction was made for the multiple comparisons between the intervention group of mothers with intellectual disabilities and the matched control group without intellectual disabilities, which could indicate spurious significance. Therefore, it cannot be certainly stated that the effects for parents with intellectual disabilities are related to the intervention or are related to other interventions offered to the parents in the same period. Moreover, it is unclear to what extent this sample of parents with intellectual disabilities was representative of all parents with intellectual disabilities, given that the classification of intellectual disabilities in this study was based on the presence of a 'cognition problem', which was defined as "the ability to think and use information" (Monsen et al., 2011: page 486).

Finally, the 'Intensive Home-based Parenting Program with a Contextual Fit', is a parenting intervention for parents with an intellectual disability (i.e., "parents were included if they met any of the three following criteria: significantly sub-average general intellectual functioning concurrent with significant deficits in adaptive behaviour (American Association of Mental Retardation 2002); (ii) attended a special education school; or (iii) who had self-identified, or been identified by the referring agency, as having cognitive limitations resulting in difficulties with learning" (Mildon et al., 2008: page 379)) with children aged 6 months through 6 years. The intervention pays specific attention to the context of the family in which the intervention is provided. The parenting program is based on other evidence-based interventions for parents with intellectual disabilities (Feldman 1994, 1998; Tymchuk 1998; Llewellyn et al., 2003), with specific strategies added to tailor the intervention to the contextual problems of these families. The added value of the strategies to fit the intervention to the context of the families was assessed

with the use of a single-group repeated measures design with 24 participants with intellectual disabilities (mean IQ: 67.58) by Mildon and colleagues (2008). However, only the contextual fit was repeatedly measured, and the other dependent variables (e.g., parent's perceived stress and quality of the home environment) were only assessed pretest, post-test, and at three months follow-up. There were small significant reductions in parenting hassles (e.g., cleaning up toys) and small improvements in the quality of the home environment. The improvements were significant for families with children aged 3-6 years, but not for younger children under three years. Parents themselves also experienced a change: they were feeling more confident and satisfied in their role as parents after the intervention. Finally, high levels of satisfaction with the intervention were reported, implying that the contextual approach was helpful.

This study indicates a preliminary first indication of the effectiveness of the 'Intensive Home-based Parenting Program with a Contextual Fit' for parents with intellectual disabilities to improve their skills and knowledge on providing adequate physical care, a safe direct physical environment, an affective atmosphere, a supportive, flexible childrearing structure, and stability in life circumstances. The evidence is limited by the single case design with only pretest, post-test and follow-up measurements for the dependent variables. In addition, the sample size was small and the sample was not randomly selected nor matched to a control sample. It is therefore possible that specific characteristics of the sample contributed to the success of the intervention. Moreover, the follow-up period was limited to only three months, meaning that no conclusions can be drawn about the long-term effects of the intervention. Overall, these limitations preclude any firm conclusions that can be made about the effectiveness of the intervention.

A combination of home-based and group-based interventions

We identified two interventions combining home and group-based sessions for parents with intellectual disabilities and a cumulation of multiple and complex problems preparing them for good enough parenthood: 'Support to Access Rural Services (STARS)' and 'Mellow Futures'.

'STARS' is a family intervention for mothers from rural areas who are "developmentally disabled and have intellectual limitations" (IQ less than 85) (Keltner et al., 1995: page 38) and have children aged 1-4 years. The intervention consists of weekly small-group meetings and home visits by a social worker. The intervention is focused on improving parent-child interactions and has a broad focus on the circumstances families live in (e.g., by inviting social services to the group meetings to explain more about how to use the service). 'STARS' is the only intervention that involves the social network of the family, inviting them to meetings to support parents in knowledge and skill acquisition (Keltner et al.,1995). The effectiveness of 'STARS' was assessed in an RCT by Keltner and colleagues (1995), in which 40 mothers were randomly assigned to the intervention group or a support group. After 12 months of 'STARS', there were still considerable deficiencies in mother-child interactions for both the intervention group and the support group. Nonetheless, the difference in the range of improvement was only significant for parents who participated in 'STARS', indicating the effectiveness of STARS for overall maternal-child interactions. Moreover, at the end of the study, parents who participated in 'STARS' reported that they felt more comfortable taking part in activities with their children and gave more positive feedback. They developed so-called teaching loops: alerting the child, providing instruction to the child, allowing sufficient time for performance, and providing feedback to the child (Keltner et al., 1995).

This study indicates a strong indication of the effectiveness of 'STARS' for parents who are developmentally disabled and have intellectual limitations in rural areas in the USA to improve the affective atmosphere in which the parent-child interaction takes place, and to improve a supportive, flexible childrearing structure. The indication for effectiveness is strong: a randomized controlled trial without severe limitations other than a modest sample size was conducted. Other minor limitations were that the study sample was a very specific population of women with very low IQ (mean IQ intervention group: 59) and from rural areas, therefore it is unclear to what extent the results can be generalized to other families. Moreover, it was not assessed to what extent the learned skills were maintained over a longer period of time.

'Mellow Futures' is another intervention that combines group-based and home-based sessions. The intervention aims to create positive parent-child interactions in expectant parents with "borderline/milder learning disabilities" (IQ above 70) (Tarleton and Heslop, 2021: page 1276), rather than strengthening parenting skills. In addition, the intervention also focuses on the context in which the mother grew up and the current context, and how this affects the relationship between parent and child (Tarleton and Heslop, 2021). The intervention was evaluated with the use of a qualitative study design by Tarleton and Heslop (2021), in which 30 mothers and 31 professionals who referred the mothers to the program were interviewed at the start and end of the intervention. Thematic analysis showed a generally positive impact of the program on bonding and interaction between mother and child. Also, for 17 of the 30 babies, concerns about child welfare were reduced after the intervention, and in one case the program helped the mother realize that she was not able to take care of the baby, which can also be seen as a positive result. However, there were four referrers (13.3%) who

stated that the intervention did not have any impact on the mother's ability to care for their baby, as mothers were not able to integrate the content into their lives (Tarleton and Heslop, 2021).

This study demonstrates program satisfaction in participants, and despite the qualitative study design, it does indicate a preliminary first indication of effectiveness, because the study investigated the change in parenting over time. Preliminary first indications of the effectiveness of 'Mellow Futures' were found for improving parents' skills and knowledge in providing an affective atmosphere, a supportive, flexible child-drearing structure, stability in life circumstances, and strengthening the social network of the family. However, the results should be interpreted with caution, given that the claims of the authors on the success of the intervention in helping expectant mothers with intellectual disabilities to take care of their children are thus based on the opinion and experiences of those who actually take part in the intervention. No valid measures of child functioning or parenting, nor an experimental design was used to test the actual effectiveness of the intervention. Moreover, it is not clear whether the positive experiences were due to the intervention itself because some mothers also received other services next to the intervention.

Table 2

Summary of Studies Reviewed

Name of Intervention	Country	Study reference	The focus of the Intervention
Home-based Parent Training Program	Canada	Feldman et al., (1992a)	Teaching of basic new-born-, infant- and child-care skills.
Child-care Training Package	Canada	Feldman et al., (1992b)	Teaching child-care skills.

Training procedure	Research Design	Outcomes Related to Good Enough Parenting	Indication of effectiveness
Home-based weekly training sessions to teach child-care skills, with the use of verbal instructions, specially designed picture books depicting each step of the task analysis, modelling of each step of the task analysis, and feedback on the mother's actual performance. When the mother performs a task correctly in the next training session, she receives a coupon exchangeable for tangible items. In each session, there is also time to discuss practical issues raised by the mother (e.g., finding a new apartment).	Randomized Controlled Trial	The intervention was effective in teaching child-care skills (e.g., diapering, bathing, feeding, safety) to mothers with low IQ whose children were at risk for child neglect,	Strong indication.
Weekly training sessions in the mother's home to teach child-care skills for which the mother had received a mean baseline score below 80%. Training consisted of verbal instructions, modelling, physical guidance, feedback, reinforcement, and if available pictorial manuals. If the mother meets the criterion of 80% correct for a skill, she receives a coupon exchangeable for items. Other topics raised by the mother, can be discussed with the trainer (e.g., finding a job, family issues).	Multiple baseline design across skills and mothers	Child-care skills were improved for all mothers after completing the intervention. The mean percentage of correct performance increased from 58% at baseline to 90% in training. Performance was maintained for 91% in follow-up. Safety steps were performed 100%.	Preliminary first indication.

Name of Intervention	Country	Study reference	The focus of the Intervention
Public Health Nurse Family Home Visiting	United States	Monsen et al., (2011)	Improve parenting skills.
Intensive Home-based Parenting Program with a Contextual Fit	Australia	Mildon et al., (2008)	Improving (a) child-care and home-environment; (b) the parent-child interaction; (c) non-corporal strategies to increase child appropriate behaviour.
Support to Access Rural Services (STARS)	United States	Keltner et al., (1995)	Improving parent-child interactions.

Training procedure	Research Design	Outcomes Related to Good Enough Parenting	Indication of effectiveness
Weekly to monthly home visits by a public health nurse for 2 years. It is unclear from the paper what the training procedure consists of.	Secondary analysis	Mothers with intellectual disabilities significantly increased their caretaking and parenting knowledge and other improved in other problem areas related to the context they are living in (e.g., income status).	Clear first indication.
Weekly home visits for a period of 6 months, focusing on at least one broad goal related to one of the three modules (a, b or c), chosen by the family itself. Skill-focused training was provided with the use of behavioural teaching strategies.	Single group repeated measures design	For all families, there was a significant reduction in parenting hassling's. The quality of the home environment was only significantly improved for families with children aged 3-6 years old. Parents felt more satisfied and confident in their role as parent after intervention.	Preliminary first indication.
Weekly group meetings for 1 year, consisting of a conversation about the learning topic, a cooking activity, sharing a meal, and practicing new skills related to the learning topic. Learning topics are generally directly related to parenting, but in some cases learning topics are more contextually related, such as health care or social skills in public spaces. In addition to the group sessions, weekly home visits are planned for reinforcement of the learned skills, and in field trips (e.g., to the public park) the skills can also be practiced. Moreover, the group take tours of common services (e.g., public health clinics) and professionals of public services come to the weekly meetings to tell more about the service.	Randomized controlled trial	After 12 months of intervention, there were still considerable deficiencies in maternal-child interactions for intervention and support groups. However, STARS mothers significantly improved from the pretest to the post-test, compared to the support group. STAR mothers felt more comfortable taking part in activities with their children and gave more positive feedback to their children. STARS mothers more frequently used teaching loops (e.g., alerting the child, providing instructions, allowing sufficient time for performance, and providing feedback).	Strong indication.

Name of Intervention	Country	Study reference	The focus of the Intervention
Mellow Futures	England/ Scotland	Tarleton and Heslop (2021)	Improving parent-child interactions.

Incorporated key elements

Several effective elements are known that may strengthen good enough parenting in parents with intellectual disabilities, as discussed earlier in this review. We examined which of these elements were used in the interventions we reviewed. 'STARS' was the only intervention that incorporated all key elements. However, based on the papers, it was sometimes unclear whether certain key elements have been incorporated in the interventions, specifically for the key element of knowledge on the legal framework of parenting with intellectual disabilities. Also, none of

Training procedure	Research Design	Outcomes Related to Good Enough Parenting	Indication of effectiveness
The intervention consists of 20-week group sessions, of which 6 weeks are pre-birth and 14 weeks are post-birth. The pre-birth sessions focus on maternal well-being, helping mothers to 'get to know their unborn baby' and learning how important warm, positive interactions are to the development of their baby. The post-birth group sessions consist of personal group sessions, in which the mother learns about how her own experiences impact her daily functioning. The rest of the day consists of a joint lunchtime, joint play, and video feedback training, where the focus is on the interaction between the mother and the child. In addition to the group sessions, a specially trained volunteer is available for the mothers on weekly basis for 1-2 hours. The volunteer helps the mother transfer the learned skills in the group to their home setting.	Qualitative interviews; thematic analysis	Out of 30 referrers, 24 reported an improved bonding and interaction between mothers and their babies. Four referrers, however, reported that the intervention did not have any impact on the mother's ability to care for the baby, as the mother was not able to generalize the learned skills to other situations. For 17 of the 30 babies concerns of child welfare were reduced after the intervention.	Indication of satisfaction and preliminary first indication.

the papers examined whether the intervention outcomes were due to the incorporation of certain key elements.

All interventions included in this review, were *preventive*, meaning that they started between pregnancy and the first 1001 days, although only 'The Public Health Nurse Family Home Visiting' and 'Mellow Futures' started during pregnancy. For most interventions, it was described that a *good working alliance* between professional and family was highly valued ('The Public Health Nurse Family Home Visiting', 'Intensive Home-based

Parent Program with a Contextual Fit', 'STARS', 'Mellow Futures'). For the 'Home-based Parent Program' and the 'Child-care Training Package', it was not clear from the paper to what extent *a good working alliance* was a key element in the intervention. This, however, does not mean that a good working alliance was not considered important within these interventions. The same applies to the key element *knowledge of the legal framework on parenting with intellectual disabilities*. Only for 'STARS' it was specifically mentioned that the professionals had to have knowledge of the legal framework of parenting with intellectual disabilities. However, most interventions did mention it (implicitly or explicitly) or referred to the duty to provide support for parents to raise their children. For example, most parents in the interventions were referred to the intervention by community professionals because of concern about mothers' abilities to adequately care for their children. All interventions were *skill-focused and made use of behavioural teaching strategies*. Also, all interventions were (partly) home-based and were *intensive* (at least 1 visit a week). However, only 'The Public Health Nurse Family Home Visiting' and 'STARS' were *long-term*, meaning lasting longer than 1 year. Finally, from what was described in the papers, only 'STARS' was *in partnership with the social network of the family*, by inviting the social network to group meetings. For example, when there were educational sessions about preventable diseases (e.g., AIDS), family members were invited to support the parents with intellectual disabilities and gain knowledge together.

Overall conclusion

The aim of this scoping review was to identify and critically evaluate preventive interventions for parents with intellectual disabilities *and* a cumulation of multiple and complex problems preparing them for good

enough parenthood in the first 1001 days. It is important to acknowledge that this review only considered interventions that were examined for their effectiveness and that this review thus does not provide an overview of all existing interventions for parents with intellectual disabilities and a cumulation of multiple and complex problems preparing them for good enough parenthood. In this scoping review, we identified six different interventions, which focused on only 6 of the 14 components of good enough parenting (as defined by Zijlstra, 2012). These interventions were limited in research on the effectiveness since none of the studies fulfilled all requirements of study quality. Moreover, in most interventions, not all key elements important for providing effective parenting support to parents with intellectual disabilities were incorporated. However, the limited evidence suggests that even when addressing only part of the components of good enough parenting and with only part of the key elements, significant and societally relevant effects on parenting skills in parents with intellectual disabilities *and* a cumulation of multiple and complex problems can be attained, with positive consequences for child development and well-being. This suggests that more comprehensive early preventive interventions with rigorous evaluations can have a major impact.

Concerning components of good enough parenting, it is striking that the focus of most interventions is on conditions within the family and is less focused on conditions in society. This may have to do with the fact that some conditions in society are not yet a problem for these families, given the developmental phase the young child is in, such as contact with peers, and education. Another possible explanation is that the conditions in society cannot be effectively addressed through parenting interventions. Nonetheless, from the ecological perspective of child development, it is important to consider the societal component in parenting

interventions as well, given that the child's development is also influenced by environmental factors in society (Bronfenbrenner, 1979; Zijlstra, 2012). Inadequate quality of only one of those conditions can already lead to damage to the quality of other conditions. For example, if a mother is behind in rent payments and worries about an eviction, the affective atmosphere is threatened because the mother is not able to be in a positive interaction with her child anymore. Subsequently, this can affect societal conditions, for example, because children have not learned positive interactions, they may experience problems in contact with peers, and there may also be a greater risk that these children will experience their own financial problems later in life (Hubler et al., 2016; McConnell et al., 2011c; Zijlstra, 2012). Therefore, it is important that interventions are responsive to all fourteen conditions of good enough parenting, to provide a context in which children can develop optimally. Currently, there is no such intervention for parents with intellectual disabilities *and* a cumulation of multiple and complex problems that have been tested for effectiveness.

In this review, we critically evaluated the effectiveness of the interventions. There were indicators that all interventions reviewed were somewhat effective in promoting good enough parenthood. With the exception of the 'Home-Based Parent Training Program' (Feldman et al., 1992a) and 'STARS' (Keltner et al., 1995), the strength of the evidence was, however, relatively weak according to the Standards of Evidence for efficacy/effectiveness study (Gottfredson et al., 2015). Moreover, none of the intervention descriptions fulfilled all requirements for an efficacy trial, and therefore the requirements for effectiveness and scale-up were not even assessed. Nevertheless, major limitations related to the study designs also resulted in the Standards of Evidence criteria not being met. For example, the use of small sample sizes, qualitative measures,

and in the case of (small) RCTs non-validated measurements, unclear descriptions of the randomization process, and non or small follow-up periods. For follow-up research, we strongly recommend conducting multiple effectiveness studies on the same intervention with strong research designs and follow-up periods of at least six months. The research design is preferably an RCT, but in some cases, this is neither feasible nor always the "golden standard". Although opinions still vary greatly on this, we advise, in line with the guidelines of Gottfredson et al., (2015), that there should be at least a control condition that did not receive the intervention. Preferably, bias should be minimized by randomization to the conditions, but as said, in some cases, randomization is not practicable or possible. Comparison series design can provide a solution in this case.

However, our critical evaluation may have been rather strict, given that the standards are relatively new. The interventions included in this review, cover a time period from 1992 till 2021. This period witnessed a shift in research methodologies and it was only in 2005 that the first set of Standards of Evidence were published (Flay et al., 2005). For example, while RCTs were less common in the 1990s, they are now the "golden standard". Moreover, as the authors of the Standards of Evidence underline, it will take years before researchers incorporate these standards into their research (Gottfredson et al., 2015). A great number of preventive research does not yet follow the research cycle at all. For example, the effects of a widely implemented intervention have been evaluated (scale-up), while a randomized efficacy trial has not been done yet (efficacy) (Gottfredson et al., 2015). Nevertheless, due to the lack of solid research, no firm conclusions about the effectiveness of the interventions can be made.

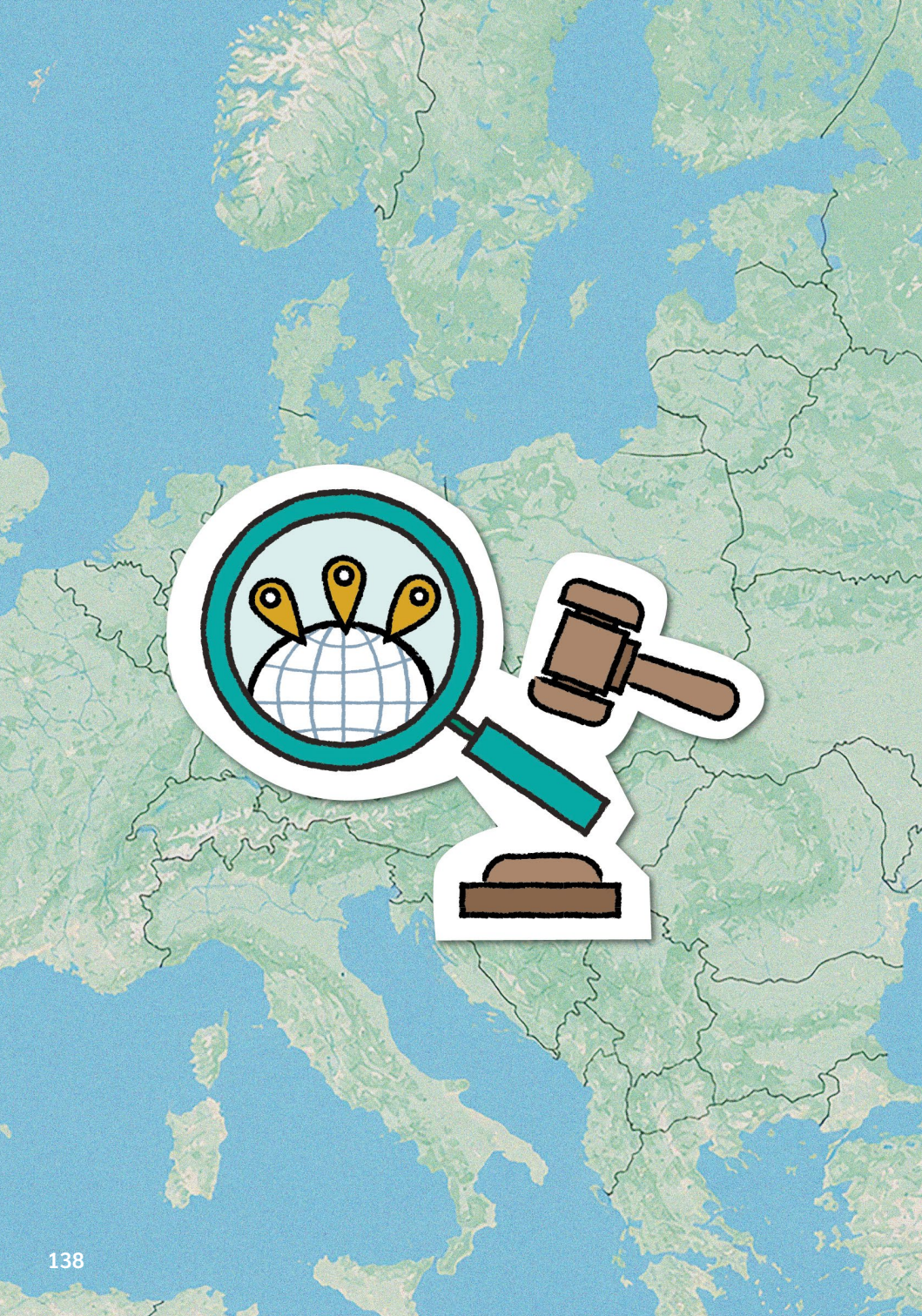
Additionally, we evaluated whether the interventions incorporated the key elements to effectively work with parents with intellectual disabilities. It seemed that only 'STARS' incorporated all key elements, while we know from the literature that these key elements are important for providing good support to parents with intellectual disabilities aimed at strengthening good enough parenting. The interventions reviewed are often of short duration, while systematic reviews underline that families with intellectual disabilities *and* a cumulation of multiple and complex problems need long-term support (Holwerda et al., 2014). Unfortunately, it is the case that professionals often lack time, training, and material resources to effectively work with these parents. This emphasizes the absence, failure, or unavailability of adequate parenting support for parents with intellectual disabilities (Castell and Stenfert Kroese, 2016; Glazemakers and Deboutte, 2013; Tarleton and Ward, 2007). Moreover, from the information in the papers, it was often unclear whether certain key elements have been incorporated in the interventions, specifically for the key elements of good working alliance and knowledge on the legal framework of parenting with intellectual disabilities. Considering the Standards of Evidence, "the intervention must be described at a level that would allow others to implement/replicate it" (Gottfredson et al., 2015: page 5), which is thus not the case for most interventions reviewed. For future studies on the effectiveness of parenting intervention for parents with intellectual disabilities *and* a cumulation of multiple and complex problems, it is advised to describe all key elements incorporated, even if only in supplementary materials. Based on the information available in the papers of the interventions reviewed, we can only conclude that not all key elements were incorporated which are important in working with parents with intellectual disabilities and a cumulation of multiple *and* complex problems.

In conclusion, this review has highlighted that there is a lack of proven preventive *effective* interventions to support good enough parenting in expectant parents with intellectual disabilities *and* a cumulation of multiple and complex problems. Existing interventions do not focus on all fourteen conditions of good enough parenting, do not include all key elements that are important to support these families effectively, and the effectiveness of the current interventions is limited. Although the knowledge is available about what is needed to effectively support these parents in overcoming unsafe parenting conditions for their new-born child, this does not yet seem to be implemented in the interventions reviewed.

However, parents with intellectual disabilities have the right to adequate and effective support in raising their children (United Nations, 2006). Furthermore, the worldwide initiative to invest in early childhood development reinforces the significance of providing preventive care to vulnerable populations during the crucial first 1000 days (World Health Organization et al., 2018). To effectively support parents with intellectual disabilities *and* a cumulation of multiple and complex problems in the first 1000 days, we strongly recommend implementing a youth care system in which preventive continuous sustainable support can be provided to families with intellectual disabilities. This preventive support must include the seven key elements as described in the introduction to effectively support these parents, which can be intensified when needed, and reduced when possible. In doing so, professionals should be supported with training and supervision in working with parents with intellectual disabilities to fit the needs of these families. Moreover, even if professionals are well trained, the child welfare system fails. Professionals often lack the time, finances, and appropriate materials to offer adequate support (MacIntyre et al., 2019; Pytlowana and Stenfert Kroese, 2021).

Therefore, governmental policy should be more aware of the needs of these families and the professionals who support them.

Regardless of the constraints of the currently available interventions and their effectiveness, the existing interventions seem to have significant and societally relevant effects on parenting skills in parents with intellectual disabilities *and* a cumulation of multiple and complex problems, with positive effects on child development and well-being. This suggests that major impacts can be achieved with more comprehensive interventions. We, therefore, recommend investing in the (further) development and evaluation of preventive interventions for parents with intellectual disabilities *and* a cumulation of multiple and complex problems focusing on good enough parenting in the first 1001 days, to shift away from a crisis-driven model towards a preventive model, in which unsafe parenting conditions for the new-born will be prevented and high societal costs will be reduced.





Chapter 6

An International Overview of Child Protection Services to Protect Unborn Children from Significant Harm

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Author contributions:

A. Zijlstra en M. R. Bruning developed the study concept. M. van Nieuwenhuijzen and B. De Castro acquired finances. A. Zijlstra conducted the data collection and the analyses. M. R. Bruning, M. van Nieuwenhuijzen and B. De Castro supervised the research project. The first draft of the manuscript was written by A. Zijlstra and edited by M. R. Bruning, M. van Nieuwenhuijzen and B. De Castro.

Abstract

This paper presents a comparative analysis of the availability of pre-birth protection orders in cases of imminent harm to the unborn child due to high-risk parenting in the Netherlands and other Western countries. Using a standardised questionnaire sent to legal experts in 14 countries, the study evaluates the legal frameworks for such orders. Findings indicate that in most countries, pre-birth protection orders are unavailable, though some offer voluntary pre-birth protection proceedings or only prenatal care and support. Pre-birth protection orders are legally available in New Zealand and Norway. However, unlike the Netherlands, these countries have specific legislation allowing such orders, and pre-birth protection orders are rarely used. The study highlights the ethical and legal challenges of mandatory protection measures, emphasising the need for a balanced approach that respects the rights of both the mother and the unborn child. Recommendations include improving the accessibility and quality of voluntary care, and if pre-birth protection orders are available, this needs an explicit legal basis since this implies an infringement of the fundamental rights of women. This research provides a comparative legal analysis, underscoring the necessity for ongoing evaluation of these measures' effectiveness and ethical implications.

Keywords: pre-birth child protection, significant harm, unborn child, legal comparative analysis.

Introduction

All parents aim to bring their children into the world in a safe, loving environment and as healthy as possible. However, some pregnant mothers and their partners fail to protect their fetus and child from significant harm. Studies show that specific maternal behaviour harms the not-yet-born child and that this harm can persist into later life. For example, consuming alcohol during pregnancy, depending on the amount, duration, diet, concurrent substance use and genetics of the mother, can significantly increase the risk of fetal alcohol syndrome (Popova et al. 2023). Fetal alcohol syndrome is characterised by neurodevelopmental disorders with or without facial dysmorphology, congenital malformations and poor growth, with lifelong consequences (e.g. Blanck-Lubarsch et al. 2020; Popova et al. 2023). But also exposure to stress, smoking, or malnutrition during pregnancy increases the risk of premature birth, low birth weight, and long-term health problems, such as cardiovascular disease, diabetes and cancer (Barker 2007; Wadhwa et al. 2009). Additionally, there is a greater likelihood of social, mental and psychological problems, such as behavioural problems, learning difficulties and addictions (Norman et al. 2012). These disadvantages can continue throughout life and even into the next generation (Black et al. 2017; Richter et al. 2017). Moreover, the father's behaviour can also harm the foetus. For example, abusive behaviour by the father towards the pregnant woman can increase her stress levels and alter fetal development (Glover and Capron 2017). In this paper, we refer to these harmful behaviours as 'high-risk parenting', which includes neglect, abuse, maltreatment, or any risk of significant harm to the child's development.

Considering the long-lasting adverse effects of high-risk parenting, preventing harm to unborn children is critical for medical, economic, psychological, educational and biological reasons (World Health Organization, United Nations children's Fund and World Bank Group, 2018). This necessity is underscored by the agendas of the WHO, UNICEF and the World Bank Group focusing on preventing harm to unborn children through early childhood parenting investments. They launched the Nurturing Care Framework in 2018, describing effective policies and services to support parents and caregivers in nurturing care (World Health Organization, United Nations children's Fund and World Bank Group, 2018). Consequently, the number of low- and middle-income countries with a national policy for early childhood development has increased by 48% (World Health Organization and the United Nations Children's Fund, 2023).

Such policies place the prevention of harm to unborn children within the context of prenatal care, considered a continuum of care from voluntary universal care, such as antenatal checkups, at one end, and mandatory care, such as child protection or the forced hospitalisation of the pregnant woman, at the other (Hermanns 2008). Ideally, high-risk parenting is prevented by scaffolding vulnerable expectant parents through voluntary care. Preventive efforts have been shown to be feasible and effective for many families (e.g. Nurse-Family Partnership as described in Mejdoubi et al. 2015). However, in some families, high-risk parenting is hard to prevent without some form of mandatory child protection order. This paper focuses on whether and how mandatory pre-birth protection orders are organised internationally.

The Convention on the Rights of the Child

From an international children's rights perspective, several standards can be deciphered. The Convention on the Rights of the Child (Conven-

tion on the Rights of the Child) 1989 grants specific inherent rights to all children under 18 (Convention on the Rights of the Child 1989, Article 1), regardless of their geographic location (CRC 1989, Article 2). While certain CRC articles and General Comments provide guidance on preventing harm to unborn children, they do not explicitly reference them. It was originally proposed to refer in Article 1 to 'every human being from the moment of his birth', but this original proposal led to considerable debate and these words were deleted from Article 1 (Detrick 1999).

However, the Preamble of the Convention on the Rights of the Child (1989) emphasizes the need for special safeguards and care for children before and after birth, stating, "The child, because of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth". However, since the Preamble is not legally binding, ratifying countries are not obligated to protect unborn children from significant harm (CRC 1989). When drafting the CRC, a prolonged discussion took place on the words 'before as well as after birth' that was also mentioned in the 1959 UN Declaration of the Rights of the Child. There was no consensus of a definition of the start of life in the CRC. Some delegations supported protection of the unborn child, but other delegations opposed these words because an unborn child was not literally a person whose rights could already be protected. The wording of the Preamble was a compromise; States Parties can adopt whatever position they wish, for the purposes of their own domestic law, on the issue of the right to life of the foetus or unborn child (Detrick 1999). Consequently, the enforcement of pre-birth child protection can vary between countries. The absence of a definition in the CRC does not preclude states legislating to protect unborn children but nor does it require them to do so or mean that 'child' must include 'unborn child'. A woman's right to choose to terminate a pregnancy and

the availability of abortion time limits are actions which can be taken to protect the unborn child.

According to Article 31.1 of the Vienna Convention on the Law of Treaties 1969, a treaty should be interpreted in (a) good faith, (b) by the ordinary meaning of the terms of the treaty, (c) in light of the treaty's context; and (d) in light of the treaty's object and purpose (for further explanation see Broughton 2010). In this context, some argue that unborn children should also be entitled to rights without discrimination (e.g. Broughton 2010).

Relevant to preventing significant harm to unborn children is Article 19 of the CRC 1989, which states that children shall be protected from all forms of violence, with parents having primary responsibility for protecting the child and the State enabling them to provide a safe environment. In cases of serious concerns regarding the child's safety, the government must intervene, preferably voluntarily, but with a child protection order if necessary. General Comment No. 13 (UN Committee on the Rights of the child 2013) outlines the various types of violence addressed by Article 19, though it does not include violence during pregnancy.

Article 3 of the CRC 1989 states that the child's best interests should be a primary consideration in all matters affecting children, including child protection orders. General Comment No. 14 (UN Committee on the Rights of the child 2013) of the CRC elaborates on this. It does not explicitly define what is in the child's best interests, but it provides an overview of reflections and considerations that should be taken into account when assessing what is in the child's best interests.

Other relevant articles include Article 6 of the CRC 1989, which protects the child's right to life and development, and Article 24 of the CRC 1989, which grants the right to the highest attainable standard of health, including adequate pre- and post-natal health care. General Comment No. 15 (2003) emphasizes the health of the unborn child. Finally, there is also a General Comment that relates to all articles of the CRC, which emphasises that children's rights also apply to very young children (zero to eight years) and that state parties should protect them (General Comment No. 7, CRC 2005).

The Dutch system

In the Netherlands, it is a common practice that child protection orders are issued for unborn children. For example, 270 unborn children were subjected to child protection services in 2014 (Raad voor Strafrechttoepassing en Jeugdbescherming, 2015). Pre-birth protection orders have been issued in cases of maternal substance abuse, domestic violence and avoidance of (prenatal) care (e.g. [2018] ECLI:NL:RBNNE:2023:3217; [2020] ECLI:NL:RBLIM:2020:10620). The Dutch Civil Code 2021 allows (provisional) child protection orders when the child's safety and well-being are at risk, and voluntary care is insufficiently accepted by the parents (2021, Article 255). However, the legislation is not explicit about the application of child protection orders for unborn children because the definition of 'child' is unclear. The Dutch legal system upholds the infans-conceptus rule, considering a child a legal person from conception if this is in their interests (2021, Article 2). However, the infans-conceptus rule is concerned explicitly with property law matters, not civil rights protection.

Moreover, the judiciary in the Netherlands is divided on applying the infans-conceptus rule for unborn children at risk of significant harm. Some

judges consider that the application of this rule depends on the viability threshold of 24 weeks, which is related to the Termination of Pregnancy Law 1984 (e.g. [2021] ECLI:NL:RBDOR:2012:BV6246). Yet, significant harm can occur early in pregnancy, as vital organs develop during this period and later damage cannot be prevented or healed (Moore et al. 2017). Consequently, there was a recent ruling where an unborn child was subjected to child protection services around the 16th/17th week of pregnancy due to seriousness of the mother's risky behaviour ([2020] ECLI:NL:RBDHA:2020:12532). This highlights the ambiguity in Dutch legislation and jurisprudence regarding pre-birth protection orders, not only as regards the possibility of imposing a pre-birth protection order per se but also as regards whether a pre-birth protection order can be imposed before the 24th week of pregnancy.

This evolving and, at the same time, ambiguous legal and policy landscape raises the question of whether and how child protection orders currently exist and are used in different countries to protect unborn children from significant harm. This paper presents an initial comparative analysis of the availability of mandatory pre-birth protection orders in Western countries.

The current study

This study examines whether and how pre-birth protection orders to protect unborn children from significant harm due to high-risk parenting are legally organised in Western countries. This is an initial step in understanding and comparing how countries address this vital issue.

Method

To examine whether and how pre-birth protection orders are organised internationally, we approached members of the International Society of Family Law from Western countries, including Ireland, the United Kingdom, Germany, Belgium, France, Austria, Denmark, Finland, Sweden, Norway, Australia, Canada, New Zealand, the United States and South Africa.

We utilised a questionnaire, asking: (1) can unborn children be legally protected by national laws and regulations in your country; (2) if so, under which laws and regulations (please copy the legal text); (3) how are these laws and regulations implemented; (4) how do these laws and regulations relate to the rights of the pregnant woman; (5) and – if they exist - how often are pre-birth protection orders imposed yearly. The questionnaire was sent to 30 members from 15 different countries. Referrals led to an additional 16 experts receiving the questionnaire. Upon receiving a response from a country, other respondents from that country were notified that their response was no longer required but still appreciated. Non-respondents were sent a reminder one week before the deadline of 1 March 2024.

Seventeen questionnaires were completed, providing information on the legal availability of pre-birth protection orders in 14 different countries. A caveat to note is that while our questionnaire did not specifically address voluntary measures, any information provided about such measures by respondents was considered a valuable by-product of the data collected. An internet search was conducted to verify and complete the information on pre-birth protection orders in each country. A summary was then written for each country and reviewed by at least the respondent

and, if possible, a second person introduced by the respondent (9 out of 14 countries had a second review). Finland did not respond and was excluded. The response from the United States was excluded due to the state-level determination of pre-birth protection orders; the number of states is too large to summarise in one paper. The final countries (12) included were Ireland, the United Kingdom, Germany, Belgium, France, Denmark, Sweden, Norway, Australia, Canada, New Zealand and South Africa.

Results

Table 1 provides an overview of the availability of pre-birth protection orders to protect unborn children from significant harm due to high-risk parenting in Western countries. Table 1 shows that most countries do not have pre-birth protection orders. These countries can be divided into two groups: those where no child protection orders are available during pregnancy, with only voluntary care and support from non-child protection organizations, and those where mandatory pre-birth protection orders are unavailable but voluntary pre-birth protection proceedings through child protection services are offered. In the latter group, families come under the provisions of child protection services, which may increase the likelihood of child protection involvement after birth. Only two other countries, aside from the Netherlands, have legislation that allows for mandatory pre-birth protection orders in cases of significant harm to the unborn child due to high-risk parenting. In this section, we describe for each country whether and how pre-birth protection orders are legally organised and provide background information on the legislative development.

Countries with only voluntary care and support

• **Belgium**

Under current laws and policies, there is no specific legal provision for pre-birth protection orders to protect the unborn child in Belgium. Child protection only can be implemented after a child is born. If there are concerns about the welfare of an unborn child, the regional authorities can take preventive measures, albeit quite limited, including providing support and assistance to the expectant parents with their consent. There is currently no explicit legal possibility in Belgium to take preventive action without the consent of the expectant parents. Indirectly, measures such as the psychiatric commitment of pregnant women are sometimes applied.

However, developments seem to be underway that will make it possible to protect the child during pregnancy through a mandatory child protection order. As seen in De Mulder (2022), several regional legal proposals (The Coalition Agreement for 2019-2024 (Government of Flanders, 2019); The Rousseau Decree 2021-2022 (Rousseau et al., 2021); the Concept Note Parys 2020-2021 (Parys et al. 2021)) describe that mandatory care for pregnant women will be developed by working with a pre-birth child protection order, based on the Dutch system. The Concept Note Parys 2020-2021 is limited to pregnant women with addiction problems, whereas The Rousseau Decree 2021-2022 (Rousseau et al., 2021) is intended to cover situations where there is a 'pregnancy of concern', i.e. a pregnancy in which the interests and development of the unborn child are seriously endangered or threatened, thus necessitating judicial child protection measures (Article 2.7 of the proposal). The proposal reads that from the 13th week after conception, unborn children can be placed under the care of a family guardian, who will supervise the

expectant mother and try to influence her "lifestyle" in a positive way. There are different opinions and criticisms about whether this will be an additional measure in the 'Decreet Integrale Jeugdhulp' (in the Integrated Youth Assistance Decree that applies explicitly to unborn children) or an extension of the current child protection system (see The Rousseau Decree 2020-2021 (Rousseau et al., 2021, p.15-16); and Concept Note Schryvers 2020-2021 (Schryvers et al., 2020, p.13)). Some see the first as preferable, as some existing measures could also be eligible for application during pregnancy, such as providing parents or parenting supervisors with an educational guideline (De Mulder 2022). Yet, these are still proposals, and currently, there is no possibility of a mandatory child protection order during pregnancy.

• **France**

In France, children cannot be subjected to child protection services before birth (Guedeney and Guedeney 2008). In case of concerns about the unborn child's safety and development, France offers a wide range of free preventive care during pregnancy, regulated by the Agency for the Protection of Mothers and Children (Protection Maternelle et Infantile, PMI). The PMI consists of more than 5,100 centres across the country offering advice on contraception, access to social services and tailor-made solutions in PMI offices or at home, provided by professionals from all disciplines.

In France, a movement emphasises the importance of the first 1,000 days (Ministère du Travail de la Santé et des Solidarités, 2020). From 2021, the government has set itself five priorities to encourage the creation of an environment conducive to the development of every child: (1) providing parents and relatives with simple, accessible and reliable information; (2) improving support for parents during pregnancy; (3) pro-

viding support in line with the needs and vulnerabilities of the parents, in particular for parents with learning disabilities; (4) encouraging parents to build a relationship with their child, by increasing the number of days of paternity leave; and (5) improving the quality of child-care for young children (Ministère du Travail de la Santé et des Solidarités, 2020). However, the use of mandatory measures to protect unborn children is not a focus of this movement.

• **Sweden**

In Sweden, there has been discussion about the possibility of pre-birth protection orders in the media (e.g. Dicksson 2018) and in court (e.g. [1987] SOU 1987:11), but currently the foetus is considered to be part of the pregnant woman's body. Therefore, no protection orders are available in Sweden before the birth of a child.

When there are concerns about the unborn child during pregnancy, different organisations can work together to provide voluntary support and assistance to the pregnant woman and her family to protect the unborn child, e.g. specialist maternal care, support for recovery from addiction, preparation for parenthood, housing and basic needs. The provision of care during pregnancy is aimed at the woman's need for support and is subject to her consent. To ensure effective cooperation, the law allows for the exchange of information between (maternal) health and social services without the permission of the pregnant woman herself if this is necessary for the protection of the unborn child (Public Access to Information and Secrecy Act, *Offentlighets- och sekretesslag 2009*:400, Chapter 26 Section 9 and Chapter 25 Section 12).

It is also possible for healthcare providers to report to social services (and vice versa) if they have concerns about the unborn child. However,

there is no obligation to report during pregnancy (Offentlighets- och sekretesslag 2009:400, Chapter 26 Section 9 and Chapter 25 Section 12). For example, social services might inform the hospital before delivery that the mother takes opioids, which is of great importance since the newborn may show severe signs of withdrawal (see, for example, [1987] SOU 1987:11, p. 82-83). When social services receive information about concerns about the unborn child, they can start a support program with the expectant parents if they agree to the support. The interventions that can then be initiated are, therefore, voluntary. A duty to report exists only after the child is born; after reporting, social services can impose mandatory interventions under the Swedish Care of Young Persons Special Provisions Act (Lagen om vård av unga, 1990, p. 52).

• Canada

Historically, Canadian provinces used birth alerts as a means to protect newborns when there were concerns about potential harm during gestation or if the mother had a history of involvement with child protection services. Birth alerts allowed social workers to request that hospital staff notify them as soon as the child was born without the parents' consent, often leading to immediate child protection orders and out-of-home placements (Sistovaris et al., 2021). As birth alerts were often based on stereotypes and assumptions, they disproportionately affected Indigenous and other racialized mothers (Sistovaris et al., 2021) and were criticised as being illegal and unconstitutional due to the lack of parental consent (Carmant 2023). Therefore, birth alerts have been discontinued across Canada (Hwang 2023).

In the current legal framework, Canadian law does not recognise unborn children as legal persons, and therefore, they cannot be protected by pre-birth protection orders during pregnancy (see for Court Cases on this

topic: Abortion Rights Coalition of Canada 2024). The Canadian approach emphasizes supporting pregnant women through voluntary prenatal care and early prevention programs aimed at promoting healthy pregnancies and childbirth (Government of Canada 2020, Chapter 3). This includes educational programs provided by community parenting and health centres. Research shows that such voluntary educational and supportive resources - covering areas like healthcare, housing, and income - significantly contribute to better outcomes for both the mother and the baby (McCalman et al. 2017). This approach prioritizes respect for a woman's autonomy while encouraging a healthy pregnancy and the birth of a healthy baby.

Court cases, such as Winnipeg Child and Family Services (Northwest Area) v DFG, [1997] 3 SCR 925, have reinforced the legal stance that unborn children do not possess rights under Canadian law. In this case, the court rejected a request for a pre-birth protection order to compel a pregnant, drug-dependent mother to enter treatment, ruling that no legal person existed to justify such an order. This decision underscores the broader legal principle that Canadian law does not recognize the unborn as legal persons with rights.

• South Africa

In South Africa, there is no express provision made for the protection of the unborn from significant harm by employing a pre-birth protection order. The constitutional protection of persons begins at birth, and unborn children are not considered persons. This was held in Christian Lawyers Association of South Africa v The Minister of Health [1998] (4) SA 1113 (T). The Choice on Termination of Pregnancy Act 92 of 1996 further solidifies this position, under which abortion is legal without any reason provided to the 12th week of pregnancy and up to the 20th week

of pregnancy if the social and economic circumstances of the pregnant woman are seriously affected; if the pregnancy poses a risk to the health of the pregnant woman; if the foetus would suffer a serious health risk; or if the pregnancy has resulted from rape or incest. Even after the 20th week of pregnancy, abortion is still legal if the life of the unborn child is at risk or there is a severe risk of birth defects. This underlines that the right to bodily integrity of the pregnant woman outweigh the right to protection of the unborn child. There has also been a case reaffirming that the unborn child is not considered a legal person. In this case of S v Mashumpa and Another (CC27/2007) [2007] ZAECHC 23; 2008 (1) SACR 126 (E) (11 May 2007), an unborn full-term baby was deliberately killed, but the judge acquitted the defendants.

It is unclear to the South Africa respondent what voluntary measures can be used when there are concerns about the child's safety and development.

• **Denmark**

The Child's Act (Barnets Lov 2024) contains several obligations for the municipality to protect the unborn child. First, it states that municipalities must supervise all children up to the age of 18, as well as expectant parents (Barnets Lov 2024, Article 9). In doing so, municipalities, citizens, and health- and care professionals have to report in case of serious concerns about the unborn child (Barnets Lov 2024, Articles 132, 133, 135). Moreover, since 2007, it has been possible to offer voluntary social support to expectant parents if it is expected that the family and child will need social support after birth.

Under the Barnets Lov (2024), it is possible to decide during pregnancy, without the consent of the future parents, on the removal or adoption

of the child immediately after birth This is a possibility if there is a clear risk of serious harm to the health or development of the unborn child in the period after birth because of the future parents' inability or lack of resources to provide appropriate care or treatment for the child (Barnets Lov 2024, Article 47(1)). However, no voluntary care is provided by child protection services during pregnancy, and only voluntary care and support are available. There are no recent figures on how often this measure has been used.

Countries with voluntary pre-birth meetings

• **Ireland**

In Ireland, there are no legal grounds for imposing pre-birth protection orders to protect an unborn child. However, voluntary pre-birth assessments do occur, which can often include recommendations that, if not followed, could lead to a basis for a care order upon birth (in line with the Guidance for the Safeguarding Process Prior To and Immediately After Birth of A Baby Where There May Be Risks of Significant Harm n.d.). This approach is an explicit choice of legislature that aims to respect the rights and choices of pregnant women within the context of Ireland's reformed legal framework.

The repeal of Article 40.3 of the Irish Constitution in 2018 is essential in understanding why Ireland does not have a pre-birth child protection order and why there is strong opposition to such a provision. Article 40.3, often referred to as the Eighth Amendment had previously recognised the equal right to life of the mother and the unborn child. It effectively provided constitutional protection for the unborn, which had implications for various aspects of Irish law, including issues related to pregnancy and abortion. This provision was repealed following a national

referendum on May 25, 2018. This allowed the Irish government to introduce more progressive legislation concerning women's reproductive rights. For example, the Health Act was introduced in 2018, which defines the circumstances under which abortion can be legally performed. The removal of Article 40.3, therefore, has direct implications for the possibility of imposing a pre-birth child protection order because the rights to life for the unborn child and the pregnant woman are no longer equal and imposing a child protection order during pregnancy could potentially conflict with the rights and choices of the pregnant woman. In post-repeal Ireland, the emphasis has been on upholding the rights and autonomy of pregnant women and ensuring their access to appropriate health care and support.

• **United Kingdom: England and Wales**

The United Kingdom (UK) consists of four separate nations: England, Northern Ireland (this is a different jurisdiction than Ireland), Scotland, and Wales. However, the legal systems concerning child protection vary across these constituent countries. This paper focuses specifically on England and Wales, which share a common legal system related to child protection.

In both England and Wales, there is no provision for court proceedings or court orders before a child's birth. This is related to the abortion law; abortion before 24 weeks is legal in all parts of the UK and in some specific cases beyond 24 weeks. Various attempts have been made in England to prevent legal abortions through injunctions or by making the child a ward of the court. Still, it has been held that a child is not a legal person and, therefore, legal action cannot be taken to intervene to protect a child before birth, see Re F (in utero) [1988] Fam 122.

Despite the lack of legal personhood for unborn children, child protection authorities in England and Wales can take action during pregnancy through child protection planning. Although legal proceedings for child protection supervision or child removal can only take place after birth. This process, which is not a statutory but guided by the Working Together to Safeguard Children Guidance (HM Government 2023), allows for the holding of a child protection conference, making a child protection plan and appointing a key worker. The guidance specifies that local protocols should address the specific needs of certain groups, including unborn children where there are concerns. Thus, Child protection planning depends on local protocols, which may vary from area to area and significantly depend on resources.

Generally, the process unfolds as follows: individuals concerned about an unborn child's welfare can contact a local authority, which will conduct an initial assessment. If this assessment indicates a risk of significant harm to the unborn child, an investigation can commence in the context of section 47 of the Children Act 1989. This investigation involves gathering information from various professionals, parents and family members to determine if the unborn child is currently suffering or is at risk of significant harm. If there is potential for significant harm, an initial child protection meeting may be held before birth. A child protection plan can be made, outlining how the child can be protected immediately after birth and into the future. Almost 900 unborn children had a child protection plan in England in 2013 (as described in Masson and Dickens 2015).

In the context of pre-birth child protection planning, it is also essential to mention the pre-proceeding system in England and Wales (Department for Education 2014; Welsh Assembly Government 2014), which is

a semi-formal process before care proceedings are initiated. The pre-proceedings process guides working with families on the edge of child protection services, even before birth (Masson and Dickens 2015). The framework outlines the steps that local authorities should take before starting child protection proceedings, provided the immediate safety and welfare of the child are not compromised. Parents are sent a letter – entitled 'How to avoid going to court' - before proceedings, which sets out the concerns of children's services and the changes they should make and invites them to a 'pre-proceedings meeting'. The aim is to involve parents in working with the local authority and to avoid child protection proceedings, or where this is not possible, to reduce conflict (Masson and Dickens 2015). The pre-proceedings process is commonly used in child protection planning in situations with unborn children; 30% of the pre-proceedings were in relation to unborn children (Masson and Dickens 2015).

• **Germany**

In Germany, the unborn child is protected against significant harm by various laws and measures, both criminal and civil (see for an overview Deutscher Bundestag 2020). This paper focuses explicitly on pre-birth protection orders under civil law. The extent to which civil protection measures apply to unborn children in Germany remains unclear. In Germany, Article 1666 of the German Civil Code (Bürgerliches Gesetzbuch 1774) provides for child protection measures to protect the child from significant harm. However, there are two perspectives on the interpretation of this Article as regards unborn children. The first perspective argues about whether protecting the unborn child under Article 1666 Bürgerliches Gesetzbuch (1774) also extends to the pregnancy period, i.e. the unborn child. The wording of the provision refers to the child as a legal person. According to Article 1 Bürgerliches Gesetzbuch (1774),

legal personality begins with the completion of birth, just as parental custody starts with birth. In addition, the Bürgerliches Gesetzbuch (1774) contains explicit provisions for the protection and legal status of the unborn child; Article 1666 is not one of these explicit exceptions.

Contrary to this, another viewpoint suggests that the unborn child already enjoys the protection of Article 1666, as strict literal interpretation conflicts with constitutional provisions safeguarding unborn life. From this perspective, constitutional protections under Article 1(1) and Article 2(2) of the Constitution (Grundgesetz 1949) support a comprehensive interpretation of Article 1666, aligning with the Constitution's principles and including the unborn child. Denying protection through family law's central authorisation would thus contradict the State's duty to protect. This is also seen in Article 6(2) of the Grundgesetz, which states that the state supervises parents' care and upbringing rights. This so-called guardianship mandate specifies the state's duties to protect the child's fundamental rights and grants the state a subsidiary care and education mandate. The guardianship mandate also covers the pre-birth period if there are specific indications that the unborn child is in danger, for example, due to the pregnant woman's drug addiction.

Regardless of a definitive decision on the aforementioned legal question, it is observed in practice that a guardian can be appointed during pregnancy (German Civil Code (Bürgerliches Gesetzbuch 1774), Article 1912 and Article 1774(2)), but their role can only commence after the child has been born. However, the guardian has no concrete power to influence the pregnant woman, which can only be exercised after birth (Deutscher Bundestag 2020).

• **Australia**

All Australian states (New South Wales, Queensland, South Australia, Tasmania, Victoria, Western Australia) do not consider the unborn child as a legal person. This limits mandatory child protection services to after a child is born (Wise et al. 2021). However, in all states of Australia, expectant parents can be reported to child protection services during pregnancy (Wise et al. 2023). This is referred to as "unborn child reports" or "prenatal reports" (O'Donnell et al. 2023). The aim of reporting to child protection services during pregnancy is to collaborate with the expectant parents to reduce risky behaviours that might affect the development and safety of the unborn child, to prevent out-of-home care after birth and to identify cases where out-of-home care is necessary after birth (Taplin 2017). However, the response to the reports varies by state.

Only in Tasmania it is mandatory to report when it is reasonable to believe that the unborn child will be suffering abuse or neglect, or may be killed by a person with whom the child will be living, or that the child needs medical treatment or intervention due the behaviour of the pregnant woman or another person (Children, Young Persons and Their Families Act 1997, Sections 3, 4 and 14). In other states, there is no reporting requirement during pregnancy, but reporting is possible. Although it is not required in New South Wales to report, once an unborn child report has been substantiated, mandatory reporters must report if the pregnant woman fails to attend antenatal services (Australian Institute of Family Studies 2020). The grounds for an unborn child report vary by state, ranging from factors such as teenage parenthood and homelessness to intellectual disability and substance abuse (for an overview, see Wise et al. 2023).

The responses to these reports differ across states. The mandatory reporting laws for each state define what must be reported; the legislative grounds define when it is acceptable for child protection services to intervene (Child Family Community Australia 2023). The states New South Wales, Western Australia, Queensland and Tasmania have specific provisions for investigating during pregnancy, stating in Queensland that there must be explicit consent from the pregnant woman to participate in the investigation, i.e. the investigation must not interfere with the rights and liberties of the pregnant woman (Queensland Government, n.d.). In Victoria, on the other hand, a report during pregnancy is not classified as a protective intervention report; thus, no investigation, substantiation, or intervention takes place (Victorian Health and Human Services 2021). Moreover, the Australian Capital Territory, Northern Territory and South Australia do not conduct prenatal investigations (O'Donnell et al. 2023; Wise et al. 2023). In the Northern Territory, the information from any report during pregnancy is used to determine whether a child protection intervention is needed after birth (Territory Families, 2020).

When the outcome of the investigation is that child protection intervention is needed after birth, child protection services remain involved until birth in the states of Queensland and the Australian Capital Territory (Community Services 2018; Department of Child Safety, Youth and Women 2020 as described in Wise et al. 2023). In New South Wales the risk assessment gives input for the safety plan, which will be made in collaboration with the expectant parents (Wise et al. 2023). Involvement of child protection during pregnancy aims to prevent risks after birth and to provide appropriate help. However, if parents avoid child protection involvement, a plan can be made in their absence to be implemented after birth. Child protection services can request a "high-risk birth alert"

from the hospital to inform child protection services when the birth is expected or when the child is born.

A study by O'Donnell and colleagues (2023) found that the rate of reports during pregnancy increased by 4% per year over seven years (2012-2013 to 2018-2019). In 2018-2019, the total number of reports during pregnancy in Australia was 24.4 per 1000 births, which equates to 5384 children. One out of three reports during pregnancy was substantiated in 2018-2019 (1529 children). Neglect was substantiated in 59% of cases, and emotional abuse in 21%.

Countries with a pre-birth protection order

• **New Zealand**

In New Zealand, the unborn child can be placed under the mandatory supervision of the Oranga Tamariki – the Ministry for Children, although this has only happened twice: In the Matter of Baby P [1995] NZFLR 577 (FC) and Re an Unborn Child [2003] 1 NZLR 115 (HC). Oranga Tamariki – Ministry for Children replaced the Government Agency for Child Protection Services in 2017 because the Government Agency was failing to meet the needs of children in need. Oranga Tamariki is child-centred and focuses on prevention and early intervention, i.e. during pregnancy (Burgess 2019).

Although rarely used, the Oranga Tamariki Act 1989 allows for a mandatory protection order to be issued before birth. This Act sets out the Ministry's care and protection powers. The premise of the Act is that the welfare and best interests of the child or young person are paramount. A report of concern can be made under section 15 of the Act. A report of concern is "a report to the agency that a child or young person has been,

or is likely to be, harmed, ill-treated, abused, neglected or deprived". When a report is received, the Oranga Tamariki may investigate the report if necessary or desirable under Section 14 of the Act. However, it is at the Oranga Tamariki's discretion whether this is necessary or desirable. The Oranga Tamariki will then decide whether to continue the investigation with a family group plan or refer the case to the court for further proceedings to protect the unborn child. Besides a (pre-birth) protection order under section 78 of the Act as referred to in this paper, other protective measures are available as described in Section 2. The court will only issue a protection measure if other measures, including a family group plan, have proved inadequate.

In 2017-2018, the Oranga Tamariki received 1,949 reports of situations of concern for the unborn child, where the unborn child was considered likely to be harmed, ill-treated, or abused. In 1,235 cases, the Oranga Tamariki offered further voluntary protection measures under Section 2 of the Act (Burgess 2019). Since its existence, only two mandatory pre-birth protection orders have been imposed.

• **Norway**

In Norway, as of 1 January 2024, under section 2-4 of the Child Welfare Act (Barnevernsloven 2024), the Child Welfare Service can open a child welfare case without the consent of the pregnant woman if a pregnant woman is admitted to an institution under Section 10-3 of the Health and Care Services Act (Lov om kommunale helse- og omsorgstjenester 2023). A pregnant woman can be admitted if there is a reason to believe that the woman is abusing intoxicants in such a way that the baby is likely to be born with a defect. She can be kept there for the entire duration of the pregnancy if other care measures cannot prevent harm to the child. The purpose of the detention is to limit the harm to the child, to

provide the pregnant woman with adequate support for her abuse and to enable her to take care of her child. After every three months of detention, the municipalities reassess whether there are still grounds for detention. Although opening a child protection case during pregnancy has only been possible since 2024, it has been possible to refer a pregnant woman to an institute under section 10-3 of the Lov om kommunale helse- og omsorgstjenester. The latest figures indicate that this happens rarely; in 2016, 28 decisions were made under sections 10-3 and 35 temporary decisions (Folkehelseinstituttet 2018). Therefore, the act seems more to be a pressure for voluntary cessation of drug use.

The child welfare service can also offer voluntary assistance and assess the need for measures after birth (Barnevernsloven 2024, Section 2-4). Moreover, since adopting the new Act, child protection services have been authorised to process personal data in cases involving unborn children (Barnevernsloven 2024, Section 13-6). However, this does not expand the responsibility of child protection services in situations involving unborn children. In the absence of a reason under Article 10-3, child protection services are still dependent on the consent of the expectant parents to open a case.

Table 1

Overview of the availability of imposing pre-birth protection orders

Country	Pre-birth protection order available	Act	Figures
Belgium	No		–
France	No		–
Sweden	No		–
Canada	No		–
South Africa	No		–
Denmark	No		–
Ireland	No, but voluntary pre-birth meetings are available.		Unknown
United Kingdom	No, but voluntary pre-birth meetings are available.		Unknown
Germany	No, but voluntary pre-birth meetings are available.		Unknown
Australia	No, but voluntary pre-birth investigations and meetings are available in New South Wales, Western Australia, Queensland and Tasmania. Prenatal reports are common in all states.		1529 substantiated reports in 2018–2019
New Zealand	Yes	Oranga Tamariki Act of 1989	It has only happened twice since the existence
Norway	Yes	Barnevernslov 2024	20–30 per year
Netherlands	Yes	Case law is based on the interpretation of Dutch Civil Code Book 1 2021, Articles 255 and 2.	270 unborn children in 2014

Summary of findings

To summarise, compared to other countries, Dutch practices regarding mandatory pre-birth child protection orders appear to be quite unusual. Most reviewed countries do not have legislation allowing mandatory pre-birth protection orders. These countries fall into two groups: those offering only voluntary care and support without child protection services, and those with voluntary pre-birth protection proceedings available from child protection services. In this first group are countries that emphasise voluntary support programmes and education to promote healthy pregnancies and births from the perspective of pregnant women's fundamental human rights, such as Canada and France, while others are considering the introduction of mandatory pre-birth protection orders, as in Belgium and Sweden. Further steps have already been taken in this direction in Denmark, where from 2024 it is possible to impose a child protection measure - in the form of out-of-home placement or adoption after birth – during pregnancy.

In the second group of countries where there are no mandatory pre-birth protection orders, voluntary pre-birth protection proceedings are available. This is the case in Ireland, the United Kingdom, Germany and Australia. In Ireland, voluntary pre-birth assessments can lead to post-birth care orders. In the United Kingdom and Australia, child protection proceedings during pregnancy require parental consent, but a mandatory protection measure can only be imposed after birth. Germany allows the appointment of a guardian during pregnancy, but their mandatory powers can only be exercised after birth. Thus, in these countries, assessments can be carried out during pregnancy with parental consent to determine whether a child protection order at birth is needed or to prevent child protection involvement at birth. However, this can still be perceived as coercion and not all parents experience this as a voluntary option.

Only New Zealand and Norway, aside from the Netherlands, have mandatory pre-birth protection orders. New Zealand uses them if other means are impractical. Norway's orders address substance abuse. However, compared to The Netherlands, these countries rarely use mandatory orders, implying that these countries have almost always persuaded the parents, through voluntary care, to prevent harm to the unborn child. Furthermore, unlike in the Netherlands, these measures have an explicit legal basis that was decided upon by a democratic process.
Overall, all included countries navigate complex legal, ethical, and social considerations for protecting the unborn child, emphasizing the need for comprehensive and nuanced approaches to prenatal care and child protection. The Netherlands stands out for frequently imposing pre-birth orders without a clear legal mandate.

Conclusion & discussion

All parents aim for a safe and healthy childbirth, but some fail due to high-risk behaviours. Preventing harm to the unborn child ideally involves voluntary care and support, but mandatory orders might be needed in exceptional cases. International treaties do not impose explicit obligations on states to protect the unborn child, leaving it an ethical debate. In the Netherlands, the judiciary regularly applies mandatory pre-birth protection orders for unborn children by applying regular child protection orders, even though they were not explicitly introduced for unborn children by the legislator. This paper examined how this Dutch practice relates to other countries with an initial comparative analysis – resulting from a collaboration between legal and child development and education experts - of whether and how pre-birth protection orders exist in Western countries to protect unborn children from significant harm, based on a methodological survey of respondents.

It can be concluded that in most countries covered in this paper, pre-birth protection orders are unavailable, and where they exist, they result from careful consideration in the form of a democratic process and political debate has been given to the reasons why pre-birth protection orders are available or not during pregnancy. For example, Ireland has explicitly chosen not to implement pre-birth protection orders in light of its legislation on women's reproductive rights. In contrast, in the Netherlands, a specific legal threshold for a pre-birth protection order is lacking, no legislative process with political discussion has been followed, and decision-making is thus left to the judiciary.

Importantly, in the countries that do have mandatory pre-birth protection orders, these are rarely used because intensive tailored assistance on a voluntary base is preferred and accepted by parents. This contrasts markedly with the situation in the Netherlands, where children's judges can impose pre-birth protection measures, and have applied them a few hundred times yearly. In this sense, the Netherlands differs considerably from all other countries in this analysis. These outcomes should motivate the Netherlands to be more reluctant to use regular child protection orders for unborn children without a specific legal basis, without political consensus, and without having tried improving (access to) services provided voluntarily.

In countries without mandatory pre-birth protection orders, a conscious decision has been made not to do so. However, this does not mean that there is no support available for expectant parents to prevent harm to the unborn child, either in the form of voluntary child protection proceedings or voluntary care and support. In some of these countries, child protection services attempt to persuade parents to accept support, while others rely solely on consent-based support due to the mothers'

fundamental rights. Studies show that voluntary care effectively prevents harm to the unborn child (e.g. McCalman et al. 2017), including in the Netherlands (e.g. Mejdoubi et al. 2015), though the high number of pre-birth protection orders there suggests underutilization or inefficacy of voluntary measures, raising questions about balancing voluntary and mandatory approaches and the effectiveness of current support systems.

Although pre-birth protection orders are unavailable in most countries, it is striking that many countries have recently shifted their focus to the protection of unborn children. This growing attention may stem from the emerging focus in the social sciences on the negative outcomes for children exposed to significant harm during pregnancy (see Introduction). For example, countries like New Zealand have already identified and acted on opportunities to protect the unborn child through mandatory measures during pregnancy. Similar developments have taken place in Norway, with the recent reforms allowing for the imposition of mandatory child protection measures during pregnancy. Meanwhile, other countries such as Belgium and Germany are actively exploring their options, reflecting a wider international effort to address this issue even in the absence of formal pre-birth protection orders.

While this comparative analysis offers valuable insights into the varying approaches to pre-birth protection orders across different countries, several limitations must be acknowledged. First, when interpreting the results of this study, the continuously developing landscape in this area should be considered. The results focus on the period up to March 2024; in the meantime, new developments may have occurred. Secondly, a comprehensive overview of the content and the effectiveness of all the measures mentioned (pre-birth protection order, voluntary pre-birth

protection proceedings, voluntary care and support) is lacking in this study. The limited use of mandatory pre-birth protection measures in New-Zealand and Norway may suggest that these interventions are not effective. Follow-up research should focus on understanding why specific legal provisions fall into disuse and the implications of a shift in emphasis towards family support.

Additionally, each country's cultural and socio-economic contexts significantly influence the effectiveness and acceptance of voluntary and mandatory child protection approaches. For example, the differences between collectivist parenting and individualistic parenting (Lansford et al. 2021), as well as austerity measures play a role in the availability and design of measures (Rajmil et al. 2020). Such influences were not included and examined in this paper. To this end, follow-up research should investigate the evaluation of these measures' efficacy and impact on protecting unborn children to understand how these contextual factors impact the outcomes of pre-birth protection measures. Finally, the study does not account for all stakeholders' perspectives, including parents, child protection workers, and legal professionals, which could provide a more comprehensive understanding of the issues at hand.

Based on this research, the Dutch approach to imposing pre-birth protection orders is exceptional internationally, and this practice seems questionable to us. Pre-birth protection orders include an intervention in a pregnant woman's life and the fundamental rights of both the mother and unborn child. Therefore, we question whether such decisions should be left to the judiciary. Relying on judges to determine if a regular child protection order can be applied in pre-birth situations, without an explicit legislative mandate, leads to legal uncertainty and potential inequality.

Therefore, we would like to make several recommendations. First, improve the accessibility and quality of voluntary care. The severe intrusion of a pre-birth protection order on a pregnant woman's life and freedom of choice - whether or not to carry the pregnancy to term – raises questions about the necessity of mandatory intervention, given the effectiveness of voluntary measures. Moreover, as follows from Article 18(2) of the CRC 1989, states must support parents in exercising their parental responsibilities and evaluate the effectiveness of the support. From this perspective, voluntary support should remain the starting point, including general antenatal care and targeted support for high-risk parents, which can reduce high-risk parenthood and avoid coercive child protection measures. The government should evaluate the provision of support and its effectiveness.

However, voluntary support can still be perceived as coercive due to the fear of mandatory measures after birth (De Mulder 2022). Both voluntary care and support, and voluntary pre-birth protection proceedings often seem to be experienced as a disguised form of pressure. In our opinion, therefore, a measure is truly voluntary only if it does not threaten to become mandatory after birth.

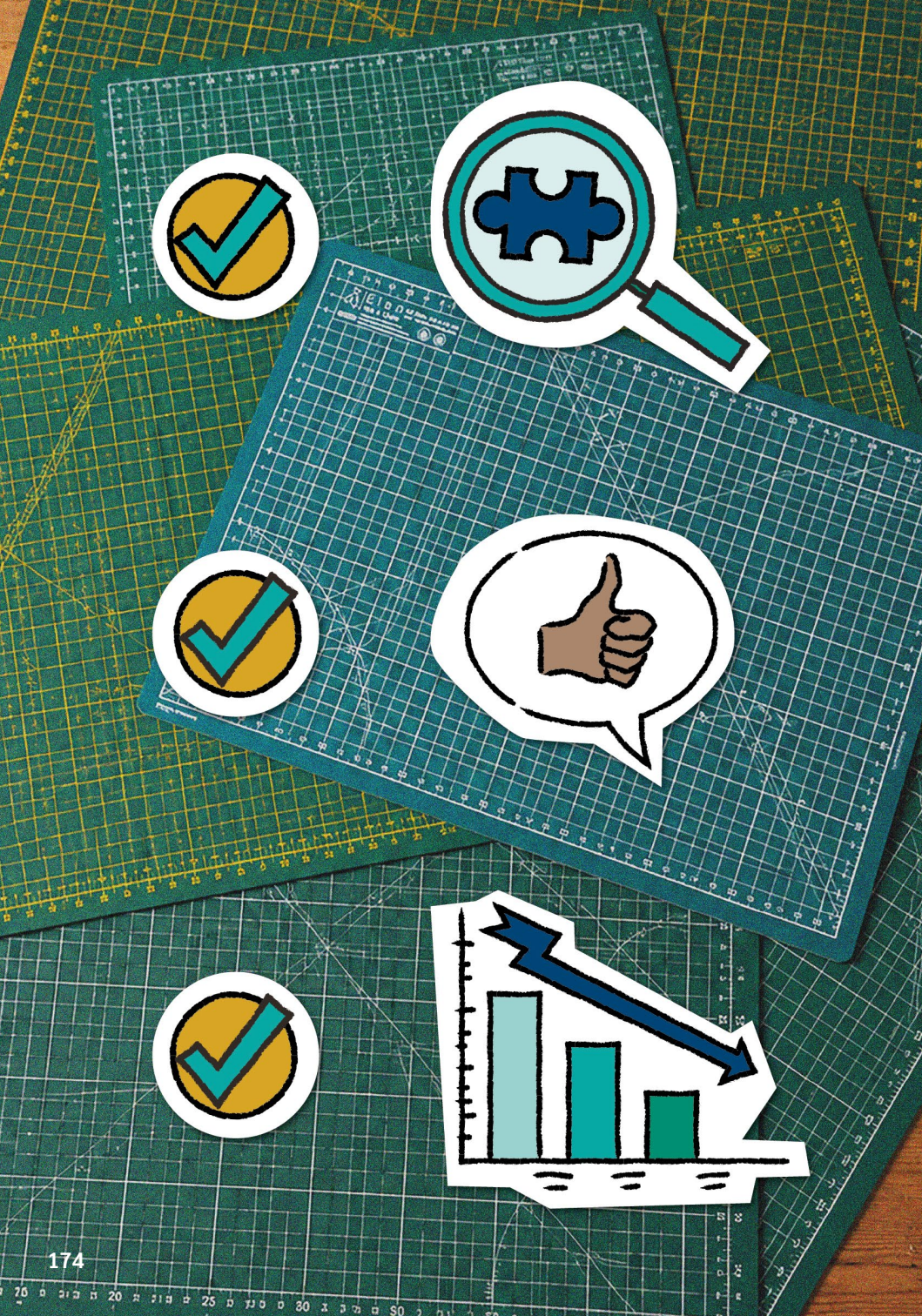
From this follows our second recommendation: whether mandatory pre-birth protection orders are possible or not should be explicitly stated in the law, resulting from a democratic process with a public and political debate about state intervention in the private life of a pregnant mother. A legal basis for pre-birth protection orders for unborn children is necessary to uphold the fundamental human rights of pregnant women. Specific in the Netherlands, the 2015 Criminal Justice Council report entitled 'Prenatal child protection and the role of the state' (Raad voor Strafrechttoepassing 2015), called for more legal powers to protect the

unborn child through a new pre-birth protection measure, as the current application of the child protection measure is not designed and tailored to the situation of the unborn child. Implementing mandatory pre-birth protection measures would necessitate that parents are fully informed about the potential consequences of their actions and behaviours (e.g. by your behaviour you are creating an unsafe situation for your child which may result in a child protection order being made). An illustrative example of this can be found in the pre-proceedings system in England and Wales.

Third, pre-birth protection orders often occur after the viability threshold, which in the Netherlands is 24 weeks. Literature shows severe damage can occur before 24 weeks (Black et al. 2017; Richter et al. 2017). Early intervention could mitigate risks more effectively and potentially avert drastic measures later in pregnancy. This highlights a significant gap in the current legal framework prioritising fetal viability over developmental safety. Policies allowing for timely and proactive protection of the unborn child are needed.

We believe that, with the above recommendations, mandatory pre-birth protection can be prevented far more often than currently seems to be the case in the Netherlands (e.g. twice in two decades in New Zealand versus 270 times per year in the Netherlands) and can only be justified in exceptional cases, in which both parents are granted legal protection, and the unborn child is protected from significant harm. Ultimately, our message is that the Netherlands should take legislative action and should no longer accept mandatory child protection orders for unborn children by applying regular child protection orders based solely on judicial discretion.

This international comparison has shown that policymakers can learn from analyzing law and practice in other countries. Individual countries' policy options may have already been tried elsewhere, with effects that may be learned from. Moreover, a practice that may have grown historically and has become 'common practice' in a specific country (such as pre-birth protection orders for unborn children in the Netherlands) may turn out to be exceptional and in need of open debate when compared to practice in other countries. We hope this review may thus contribute to societal discussion on protecting unborn children and the roles of voluntarily providing high-quality support and possibly protecting orders therein.





Chapter 7

An intervention for expectant parents with intellectual disabilities with child's safety concerns: A feasibility study

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Author contributions:

M. van Nieuwenhuijzen and B. Castro developed the study concept and acquired finances. A. Zijlstra conducted the data collection and analyses, and drafted the manuscript. M. van Nieuwenhuijzen and B. Castro supervised the research project and revised and edited the manuscript.

Abstract

Background. Parents with intellectual disabilities often face challenges during pregnancy that may impact child safety. Early intervention is crucial to mitigate risks. Safe Start is a prenatal safety-planning intervention. This study assessed Safe Start's feasibility.

Method. Five families and their youth care workers assessed the application of nine working elements, i.e., the ways in which youth care workers collaborate with parents, parental appreciation of youth care worker and intervention, and child safety outcomes in terms of changes in dynamic risk factors.

Results. Most families identified the majority of the working elements, and youth care workers reported substantial application of these elements. The youth care worker and the intervention were generally well appreciated by parents. Across families, child safety risks declined, and dynamic risk factors decreased in three families.

Conclusions. Preliminary findings suggest that Safe Start may be feasible and appreciated, with promise for improving child safety.

Keywords: parenting; intellectual disabilities; expectant parents; pregnancy; intervention.

Introduction

Like all parents, parents with intellectual disabilities generally aim to bring their children into the world in a safe, loving environment and as healthy as possible. Research shows that, when adequately supported,

many parents with intellectual disabilities can provide good-enough parenting , promote positive developmental outcomes for their children, and offer a safe upbringing (e.g., Collings et al., 2021; IASSID, 2008). However, for some children of parents with intellectual disabilities, a combination of commonly experienced risk factors may challenge a successful start in life. According to the contextual-interactional model of parenting (Feldman & Aunos, 2020), interactions between individual characteristics, social circumstances, and environmental factors shape parenting outcomes. This model underscores that parenting outcomes are thus not solely related to the intellectual disability itself, but pertain to factors such as psychiatric and behavioural difficulties, mental health issues, histories of adverse childhood experiences, poverty, limited access to education and healthcare, stigma, and difficulty navigating complex systems of support.

These challenges can accumulate over time, sometimes beginning during pregnancy (Zijlstra et al., 2024), and continuing throughout the parenting journey, leading to heightened stress for parents (Meppelder et al., 2015; Wilson et al., 2013). Elevated stress levels, particularly in the absence of appropriate support, may increase the risk of parenting difficulties that can affect child safety and well-being (Aunos et al., 2008). In addition to the fact that the parenting difficulties are not inherent to intellectual disability itself, it is essential to recognise that not every parent with an intellectual disability experiences risks and problems to the same extent. Differences in abilities, strengths and access to informal and formal support systems mean that many parents are well equipped to meet their children's needs, especially when support is timely, accessible and tailored (e.g., Collings et al., 2021; IASSID, 2008).

However, for families facing a cumulation of risks, without timely and adequate support, these risks may lead to adverse birth outcomes, poor developmental outcomes, adverse childhood experiences, and severe and costly problems later in children's lives (Collings et al., 2012; Emerson & Brigham, 2014; Hindmarsh et al., 2017; Höglund et al., 2012; McConnell, 2011), with consequences even for the next generation (St-Laurent et al., 2019). Moreover, the social costs are high: in 2021, the average Dutch municipality spent an average of €10,207 per youth receiving care (Jeugdautoriteit, 2022). Although not specific to the youth of parents with intellectual disabilities, these figures illustrate the substantial societal costs associated with youth care when support is provided late or after problems have escalated. These outcomes often reflect missed opportunities for early, preventive support, rather than parental incapacity. As the contextual-interactional model suggests, this escalation demonstrates not just the challenges faced by parents but also the failure of systems to provide accessible, meaningful, and timely support (Feldman & Aunos, 2020).

There is a broad consensus on the need for early, preventive intervention (Dodge, 2019; O'Keeffe & O'Hara, 2008). Current preventive interventions around pregnancy for at-risk families have shown that families with modest risk without an intellectual disability can be supported effectively (e.g. Nurse-Family Partnership as described in Mejdoubi et al., 2015). However, these interventions do not adequately address the extreme accumulation of risk and unsafe conditions among expectant parents with intellectual disabilities and multiple and complex problems. They therefore cannot provide sufficient scaffolding to prevent unsafe conditions, nor clarity necessary to address imminent unsafe conditions in the interest of the child (Slayter & Jensen, 2019). There is a lack of proven, effective voluntary preventive interventions specifically for these

parents to promote good-enough parenting in the first 1000 days of life (Coren et al., 2018; Hanson et al., 2023; Zijlstra et al., 2023). The interventions available appear to have some effects on good-enough parenting, but the evidence is too weak to draw firm conclusions about their effects (Zijlstra et al., 2023).

Current interventions for families with intellectual disabilities and multiple risks may still be too narrow in scope for these extremely troubled families (Zijlstra et al., 2023). Interventions for parents with intellectual disabilities focus mainly on strengthening the parent-child relationship and parenting skills (e.g., VIPP-LD as described in Hodes et al., 2017), but do not address the organisational and institutional environment in which these families function (McConnell et al., 2008). Similarly, a recent scoping review shows that most interventions for parents with intellectual disabilities promoting good enough parenting in the first 1,000 days do not include all seven key elements for effectively supporting these parents – summarised as 'preventive', 'good working alliance', 'knowledge of the legal framework on parenting with intellectual disabilities', 'skill-focused and made use of behavioural teaching strategies', 'home-based', 'intensive and long-term', and 'in partnership with the social network of the family' - as outlined in Zijlstra et al. (2023). In addition to these evidence-based approaches, practice-based interventions also exist, often developed to address specific challenges faced by parents with intellectual disabilities and multiple risks. Both evidence-based and practice-based approaches usually lack an integral approach to ensure children's safety in close cooperation with the expectant parents and aligned with the needs and possibilities of parents with intellectual disabilities.

This study examined the feasibility of Safe Start, a coordinating intervention, designed for and with expectant parents with intellectual disabilities, where concerns about the safety and development of the baby and the parenting skills of the expectant parents arise due to cumulative personal and contextual challenges. In Safe Start, youth care workers do not provide direct care, but coordinate and align support together with parents, their social networks, and involved professionals. The intervention focuses on jointly identifying risks and strengths and in organising the necessary support to ensure a safe start for the child and prevent OOHP if possible. Central to Safe Start are a set of working elements that describe how the youth care worker collaborates with parents and their networks throughout the intervention (see Box 1). These working elements guide professional practice and reflect three core principles of working effectively with parents with intellectual disabilities: Safety, Partnership and Future.

The aim of Safe Start is threefold: (1) To achieve and ensure a safe environment and development for the child; (2) To enable parents to take the responsibility of parenthood, if necessary, with support; and (3) If the parents are not the primary caregivers of the child, to keep the bond between parents and child intact. The intervention starts during pregnancy, at 25-32 weeks of gestation, and continues until six months postpartum. Youth care workers operationalise the working elements primarily through home visits and multidisciplinary meetings, during which they collaboratively assess risks and strengths with parents, their social networks, and involved professionals. Based on this shared understanding, youth care workers coordinate appropriate professional support.

Box 1

Working elements of Safe Start

Working element	Question(s) for parents	Question(s) for youth care worker
Acknowledge parenthood	Do you feel seen as a parent of your child, by the youth care worker?	To what extent has attention been paid to the recognition of parenthood?
Working in partnership	Did the youth care worker involve you sufficiently in the Safe Start process?	To what extent did you work in partnership with parents?
Feeling OK with who you are and with what you can and cannot (yet) do	Did the youth care worker paid attention to your past and upbringing?	To what extent has the parents been recognized in how they are?
Providing a basis for living	Did the youth care worker paid attention to your practical issues?	To what extent has the basis for living been addressed?
Enhancing parent skills	Did the youth care worker paid attention to improving your parenting skills?	To what extent has attention been paid to improving parents' parenting skills?
Building a support network	Did the youth care worker paid attention to expanding your social network?	To what extent has attention been paid to expanding parents' support network?
Fair analysis	Did the youth care worker give equal attention to what went well and what did not go well yet?	To what extent was a joint honest analysis done, in which there was equal attention to what went well and what did not go well yet?
Integral cooperation	Did the youth care worker collaborate with other social workers involved with your family?	To what extent was integrally worked with other social workers/agencies?
Aligning with the intellectual disability	Do you think the youth care worker was responsive to your questions and problems? Do you think the youth care worker was clear, open and honest in communication? Do you think the youth care worker was respectful to you? Do you think the youth care worker did believe in your abilities?	To what extent have you adapted your attitude and approach to the specific needs of parents? To what extent do you believe that parents can learn and develop?

How Safe Start Works

• **Safety**

Ensuring the child's safety is the core aim of Safe Start. Central to the intervention is the development of a personalised safety plan in close collaboration with parents, their social network, and professionals, detailing actions and responsibilities during each stage of pregnancy and early infancy. For example, if the mother experiences depressive feelings and becomes less emotionally available to her child, the safety plan specifies who will temporarily take over aspects of care to meet the child's needs and safety. To develop the safety plan, tools are used, including the circle technique (in Dutch: De Cirkeltechniek) (Visser, 2020), which helps parents visualise risks and strengths related to caregiving.

Collaboration with other organisations is an integral part of the intervention. Safe Start actively coordinates with numerous services and incorporates other interventions, such as VIPP-LD and the Nurse-Family Partnership program, to address families' multifaceted needs. In one case, for example, a pregnant mother was experiencing severe stress due to unstable housing. The Safe Start youth care worker then arranged with the housing service to expedite her application for stable accommodation, and engaged mental health services to provide stress management support. At the same time, the youth care worker introduced the Nurse-Family Partnership, which offered home-based support and guidance on parenting and maternal health. Concurrently, prenatal care providers monitored the baby's development and shared updates during regular multidisciplinary meetings facilitated by Safe Start.

By taking on a coordinating role, Safe Start ensures that all involved organisations and interventions work together under a unified strategy,

avoiding fragmented care and conflicting advice, focusing on child safety while creating a cohesive and effective support system for the family. In this way, Safe Start incorporates the first two key elements of working effectively with these parents: attention to context and prevention.

• Partnership

Safe Start is a voluntary intervention, fostering a collaborative relationship between parents and the youth care worker. Families are actively involved in decision-making, including the development of the safety plan, which promotes a sense of ownership and empowerment. Youth care workers receive extensive training to collaborate with parents with intellectual disabilities. They are required to have completed at least a bachelor's degree in a relevant field within the social domain, and to have a minimum of two years of professional experience working with individuals with intellectual disabilities within the context of child protection. Their nine-month Safe Start training program equips them with practical skills tailored to the needs of parents with intellectual disabilities, such as task analysis, positive reinforcement, and corrective feedback (Feldman, 1994). Workers also learn about the legal and systemic frameworks relevant to parents with intellectual disabilities, enabling them to effectively address the family's unique needs (Hanson et al., 2023).

A partnership-oriented approach addresses the following key elements: working alliance, knowledge of the legal framework for parenting with intellectual disability, and skill-focused and behavioural strategies.

• Future

Recognising the importance of sustainability and the long-term support parents with intellectual disabilities often need, Safe Start focuses on

establishing a sustainable support system through a gradual and phased-out intervention model. Safe Start begins with intensive, home-based support (2–3 visits per week), which is reduced over time (to fortnightly or monthly visits) as parents develop resilience and confidence (Damen et al., 2018).

A key component of this approach is strengthening the family's social networks. Youth care workers assist families in identifying and engaging supportive individuals within their network, such as relatives, friends, and community members, to provide ongoing support. Youth care workers use tools such as genograms and bubble charts to identify supportive individuals who can provide ongoing support. Parents are encouraged to involve these individuals in regular family meetings to reinforce their support system.

Youth care workers also help families connect with community resources, such as parenting classes and peer support groups. These connections help ensure that even after the program ends, parents have a durable support structure in place. Additionally, the program incorporates empowerment strategies that encourage parents to practice skills, make decisions, and seek help when needed. At the end of Safe Start, Safe Start hands responsibility for further support back to the municipality, ensuring continuity of care within the local support system. In this way, the intervention incorporates the key elements of home-based, long-term, intensive, and partnership with family and social networks.

The present study

Currently, a growing number of municipalities in the Netherlands call on Safe Start to support parents with intellectual disabilities during pregnancy and the first months. Hence, we decided to conduct a small-scale

feasibility study. We examined the feasibility of Safe Start by assessing parents' and youth care workers' reports on the application of the intervention's working elements, investigated parents' appreciation of the youth care worker and the intervention, and explored whether dynamic risk factors decreased during the intervention, as a first indication of improved child safety.

Method

Intervention

Safe Start is a voluntary intervention, meaning it is applied only when parents are open to help. When the father is unwilling to cooperate, but the mother is, implementing Safe Start may still be considered. Fathers are regarded as essential partners in Safe Start, given the critical role paternal involvement plays in child safety, development, and family functioning (Van Nieuwenhuijzen et al., 2025). Therefore, Safe Start actively seeks to involve fathers. However, when a father is initially unwilling or unable to participate, Safe Start does not want to withhold support from the mother and child. In such cases, Safe Start youth care workers continue to make targeted efforts to engage fathers, particularly when they have custody. The intervention is frequently applied with parents with intellectual disabilities, although having an intellectual disability is not a prerequisite for participation.

The program provides a detailed week-by-week guide for youth care workers, outlining the topics to discuss and actions to take at each stage:

- **Phase 1** (Safe Pregnancy): Identify risks, promote self-care, and create a safety plan.
- **Phase 2** (Safe Delivery): Prepare for childbirth, finalise safety plans,

and offer practical and emotional support.

- **Phase 3** (Safe Parenting): Support parents in adapting to newborn care, update the safety plan, build confidence, and provide support.
- **Phase 4** (Safe Future): Consolidate support networks, foster self-reliance, and plan for independence.

These guidelines are not set in stone, allowing the youth care worker to use tools and methods to tailor the safety plan to each family's specific needs and circumstances. A shortened program applies when starting at 32 weeks of gestation. This approach combines structure and flexibility, ensuring that Safe Start adapts to each family's unique dynamics and needs while maintaining its goal of securing a safe environment for the child.

Design

For this study, we followed five families during and after the intervention. We measured feasibility constructs (parental identification of the working elements and youth care workers' ratings of the application of the working elements). Furthermore, we assessed parental appreciation monthly and at post-intervention using a general rating of the intervention and the youth care worker. Finally, we used a pre-post-test within-subjects design to investigate changes in risk factors over time, providing insight into potential improvements in child safety.

Participants

Between July 2022 and January 2023, 12 parents enrolled in Safe Start, of whom 5 families participated in the study. The main reasons for not participating were the high involvement of social workers (5) or a lack of interest in the study (2). For privacy reasons, we cannot compare parents who did participate with those who did not. All five of the participating

families were headed by a mother and a father . For families 1 and 5, it was their first child. For family 2, it was their second child. For family 3, it was the mother's second child and the father's first, while child protection services placed the mother's first child out of the home. Both her children were subject to child protection services. For family 4, it was their third child. Their first child lived at home, while child protection services placed their second child out of home at birth. Also, both their children and the unborn child were subject to child protection services. All five families experienced challenges across individual, social, and environmental domains. Box 2 presents the duration of the pregnancy at the start of the intervention and the parents' ages for each family. Contrary to the inclusion criteria, family 5 had a start date before 25 weeks' gestation to evaluate whether Safe Start would also be appropriate for families with such an early start date.

Procedure

The Ethics Review Board of the University of Amsterdam (2022-CDE-14550) approved the study procedure. The municipality referred parents to the intervention. The youth care worker at Safe Start informed parents about the study via an information letter. Interested parents provided consent to be contacted by the researcher, who offered detailed study information and obtained active consent using materials adapted for individuals with intellectual disabilities (plain language, pictograms). Before this study, we consulted parents with intellectual disabilities to ensure the documents were understandable to them.

Box 2

The number of weeks pregnant and parental age at the start of the intervention

	Number of weeks pregnant	Mother's age	Father's age
Family 1	33	27	29
Family 2	29	37	38
Family 3	30	35	21
Family 4	26	28	28
Family 5	12	18	17

We followed the parents monthly throughout the intervention and post-intervention. At the start and end of the intervention, standardised questionnaires were administered conversationally at home visits by the researcher. The monthly contacts were via WhatsApp, email, or phone, depending on the parent's preference. Monthly contacts addressed parental and child well-being, child safety, goal attainment, appreciation of the youth care worker, and, in case of custodial placement, parental acceptance. The home visits focused on parental well-being, child development, and general safety. At the end of the intervention, we asked parents to evaluate Safe Start using standardised questions during the home visit. Separately, we asked the youth care worker to evaluate Safe Start for the specific family using standardised questions. For this study, we used only the measures related to the constructs of feasibility, appreciation, and child safety.

Measures

Feasibility

We assessed feasibility according to parents using standardised questionnaires during the home visits. The researcher interviewed the youth

care worker separately regarding feasibility. Both parents and yourh care worker rated the quality of delivery, operationalised through the identification (by parents) and application (by youth care workers) of the working elements (as described in Box 1). The working elements represent the concrete ways in which youth care workers collaborate with parents and their social networks throughout the intervention. This approach aligns with the concept of fidelity of implementation (O'Donnell, 2008), referring to the degree to which the intervention was delivered without deviations from the planned protocol. Feasibility, in this context, involves evaluating how effectively youth care workers delivered the intervention within the given context. Parents rated whether the working element was present within their trajectory on a Likert scale as (0) no; (1) a little bit; or (2) yes. In this paper, we describe for each family how many working elements they recognised. For working element 9, we used the most frequently given answer from the four questions. The youth care worker rated the extent to which they applied the working element on a scale from 1 to 10, where 1 indicates the working element was not present and 10 indicates it was. The average rating was calculated across all nine working elements for each family. Box 1 presents the working elements with the questions for parents and youth care workers.

Another indicator of the quality of delivery was parents' and youth care workers' ratings of the extent to which they felt Safe Start contributed to a safe start for the child. The answering options for both parents and youth care workers were the same as for the nine working elements. In this study, we used the same Likert-scale distribution for parents as the feasibility scale and a 1-10 rating provided by youth care workers.

Participants appreciation

Parents rated the support provided by the youth care worker monthly on a scale of 1-10, where 1 indicated they did not experience any support

from the youth care worker and 10 indicated they experienced strong support. We also asked parents about their experience with the support at the end of the intervention during the home visit. Parents were asked to rate the intervention and the youth care worker on the same scale across the whole trajectory. An average rating for the youth care worker during the trajectory and after the trajectory is provided, as well as an average rating of the intervention afterwards. Moreover, we asked parents whether they would recommend Safe Start to a friend or family member in need, using a Likert scale of (0) strongly disagree; (1) somewhat agree; (2) agree, which we will describe in this paper.

Child safety

Improvements in child safety were assessed for the unborn child for whom Safe Start was initiated. We assessed child safety by filling in the Actuarial Risk Assessment Tool for Youth Protection (in Dutch: Actuarieel Risicotaxatie Instrument voor Jeugdbescherming; hereafter ARIJ) (Van der Put et al., 2015) at the start and end of the intervention. To complete the ARIJ, information was gathered from the home visit with the parents and the child's case file, as intended (Van der Put et al., 2015). The ARIJ is a validated instrument for risk and safety assessment (Vial et al., 2020). The ARIJ consists of two components: a safety assessment and a risk assessment. The safety assessment identifies immediate child unsafety; the risk assessment can be used to estimate the risk of future unsafety (Van der Put et al., 2015). Box 3 presents an overview of the safety and risk factors assessed in the ARIJ.

The safety assessment consists of ten items that identify immediate safety concerns. Each item can be scored as 'yes', 'no', or 'unknown'. In case of 'unknown', the professional should discuss the topic with the parents to clarify the situation. A 'yes' score on one or more items indicates that the child's safety is at risk.

The risk assessment consists of thirty items that estimate the risk of future child unsafety. These items are divided into static (7) and dynamic (23) risk factors. Every item can be scored as 'yes' (1 point), 'no' (0 points), or 'unknown'. The total risk score is calculated by summing all static and dynamic risk factors, resulting in a general risk profile with the following categories: low risk (0-3 risk factors), medium risk (4-7 risk factors), and high risk (8 or more risk factors). In addition the general risk profile, a dynamic risk profile is calculated by summing only the dynamic risk factors, resulting in the following categories: low risk (0 risk factors); low to medium risk (1-2 risk factors); medium risk (3-4 risk factors); medium to high risk (5-7 risk factors); and high risk (8 or more risk factors) (Van der Put et al., 2015). For this study, we examined changes within each family by comparing the safety assessment scores and the number of dynamic risk factors over time. In this study, we did not include static risk factors and the overall risk profile, as these are not sensitive to change and therefore do not offer insight into potential indications of the intervention's relevance or added value within this limited feasibility sample.

Box 3

Risk Factors Assessed in the ARIJ

Safety items	
1.	There is (acute threat of) physical abuse of the child
2.	There is (acute threat of) sexual abuse of the child
3.	There is (acute threat of) severe neglect of the child
4.	There is (acute threat of) severe domestic violence in which a child is present
5.	There is (acute threat of) psychiatric problems in the parent(s) that put the child in immediate danger
6.	There are behavioral problems in the child that cause him/her to endanger himself/herself
7.	There is an (acute threat of) other harm caused by others
8.	There is (acute threat of) severe psychological maltreat
9.	There is an (acute threat of) abduction of the child
10.	There is another form of direct child insecurity, namely:
Dynamic risk items	
There are facts/concrete evidence pointing to recent (= between now and three months ago)	
1.	Physical violence (against the child)
2.	Sexual abuse (of the child)
3.	Psychological violence (against the child)
4.	Neglect (of the child)
5.	Domestic violence (in the family)
There are concerns about:	
6.	Protection and safety
7.	Basic care
8.	Rules and boundaries
9.	Stability
Other dynamic risk factors	
10.	Educator(s) has psychiatric problems (e.g., anxiety problems or depression)
11.	Educator(s) has addiction problems related to substances
12.	Educator(s) is physically absent
13.	Educator(s) is emotionally absent
14.	Educator(s) has a problematic partner relationship

15.	There are many conflicts between family members
16.	Educator(s) is in social isolation or educator(s) has many social conflicts
17.	Educator(s) has stress due to material and/or financial problems (e.g. unemployment, debt or homelessness)
18.	Educator(s) experiences stress in the family (due to divorce or illness, for example)
19.	Educator(s) is dominant (strict, unjust and/or overly controlling parenting behavior)
20.	Educator(s) insufficiently regulates own anger
21.	Educator(s) view identified parenting problems as less serious than the social worker
22.	Educator(s) is insufficiently willing and/or able to change own (parenting) behavior
23.	Educator(s) perceives child as problem
Static risk factors	
24.	Educator(s) has had previous contact with a child protection agency
25.	Educator(s) has an intellectual disability
26.	Educator(s) has experienced victimization of some form of child abuse in his or her childhood
27.	Educator(s) used physical violence against a person outside the family
28.	Educator(s) has exhibited criminal behavior (evidenced, for example, by convictions and/or police contacts)
29.	Educator(s) was violent at home in the past (more than 3 months ago)
30.	The child is under 5 years of age

Results

Feasibility

Overall, parents generally recognised most of the working elements of Safe Start. Four out of five families identified between 7 and 8 elements as present, with only minor variations. One family (family 1) identified fewer elements. To illustrate the variation between families, Table 1 presents the results per family. All the working elements were identified by at least two families, except the working element of building a support

network, which was only identified by family 5. These findings indicate that, even with a small sample, the working elements were mostly identified by parents, supporting the feasibility of the intervention.

The general ratings of the extent to which youth care workers applied the working elements for each family ranged from 6.91 to 8.18 (on a 1-10 scale). Table 1 provides the ratings by each family. The element 'building a support network' scored lowest here as well, with a mean score of 5.4. All other working elements scored above 6.6. While there is some variation between families, these scores suggest that the working elements were delivered consistently.

In three cases (families 2, 3, and 5), the parents reported that Safe Start contributed to a safe start for their child; family 4 reported that Safe Start contributed a little bit; and family 1 did not report any contribution from Safe Start. Youth care workers rated Safe Start's contribution to a safe start, on average, at 6.6 (*SD* = 0.89, range 6-8). Table 1 presents parents' and youth care workers' opinions on Safe Start's contribution to a safe start.

Appreciation

The average monthly appreciation by parents of the youth care worker ranges from 3.83 to 8.61 (on a 1-10 scale) (see Table 1). However, four out of five families scored on average 7 or above. The afterwards appreciation score of the youth care worker over the whole intervention period was 8 (for families 2, 3, and 4) and 10 (for family 5), while family 1 scored 1.

Appreciation of the intervention also differed strongly between families. Three families (families 2, 3 and 5), gave an eight on a ten-point scale. In contrast, two other families (families 1 and 4), gave a one. In the com-

ments, family 1 indicated they were not satisfied. Family 4 indicated the intervention was not helpful for them, but they found it very appropriate for single parent families, and for such families would score it between 8 and 9. In line with this, family 4 would recommend Safe Start to a friend or family member who needs it, just as families 2, 3 and 5 did.

Child safety

For all children, safety conditions had improved after the intervention. The number of safety risks decreased in all families, with a reduction of 1 to 3 safety risks. For three out of five children, the number of dynamic risk factors also decreased. The number of dynamic risk factors for the other two children remained the same. Table 2 shows the number of safety and dynamic risk factors at the intervention's start and end. At the end of the intervention, all the children (for whom the intervention was initiated) lived at home with their parents.

Table 1

Results of feasibility and appreciation

	Identification of the working elements				Contribution of Safe Start to a Safe Start
	Elements 'yes'	**Elements 'a little'**	**Elements 'no'**	**Youth care worker (rating out of 10)**	**Parents (no/a little bit/yes)**
Family 1	1	2	6	7.55	No
Family 2	7	0	2	7.50	Yes
Family 3	8	0	1	8.18	Yes
Family 4	7	2	0	7.36	A little bit
Family 5	8	1	0	6.91	Yes

Table 2

Safety- and risk factors at the start and the end of the intervention

	Number of safety risks		
	Start	**End**	**Difference**
Family 1	1	0	1
Family 2	1	0	1
Family 3	3	1	2
Family 4	3	0	3
Family 5	1	0	1

a Van der Put et al., (2015).

		Appreciation		
Youth care workers (rating out of 10)	Average appreciation of the youth care worker over the whole trajectory	Afterwards appreciation of the youth care worker	Appreciation of the intervention	Recommend Safe Start to a friend/family member in need
6	3.83	1	1	A little
6	7.86	8	8	Yes
8	7.00	8	8	Yes
7	7.00	8	1	Yes
6	8.61	10	8	Yes

	Number of dynamic risk factors			
Start	Risk profile at the start[a]	End	Risk profile at the end[a]	Difference
7	Middle-High	2	Low-Middle	5
7	Middle-High	7	Middle-High	0
4	Middle	4	Middle	0
9	High	7	Middle-High	2
9	High	5	Middle-High	4

Discussion

The present study explored the feasibility, appreciation, and improvements in child safety of Safe Start, a tailored intervention for expectant parents with intellectual disabilities. Five families participated in this study, for all of whom there were concerns about child safety. Despite varied outcomes, the overall findings were encouraging. Most families identified the intervention's working elements, and youth care workers also expressed satisfaction with its application in the given context. However, the working element of building a support network was less recognised by parents and applied less by youth care workers. The parents appreciated the youth care worker and the intervention itself. These families would recommend Safe Start to a friend or family member in similar circumstances. While improvements in child safety were evident across all families, baseline safety scores were already relatively low, leaving limited room for further improvement. However, this is understandable, given that the presence of even a limited number of safety items indicates an acute threat to the child's safety and requires immediate intervention within 24 to 48 hours. As such, even a small number of safety risk signals a sincere concern, and any reduction is considered meaningful. In addition, dynamic risk factors decreased in three out of five families. However, despite these reductions, risks often remained in the medium-to-high range. This result emphasises the importance of exploring long-term effects to determine whether these reductions are sustained, continue to improve over time, or require continued cooperation with families to prevent relapse.

Interestingly, one family's scores for feasibility and appreciation were exceptionally low but showed the most decrease in dynamic risk factors. This discrepancy highlights that even when families struggle to identify

or engage with Safe Start's working elements, the intervention may still contribute to positive outcomes. Family 1's case also underscores the importance of adapting interventions to the diverse needs and circumstances of families. For example, Family 1 was not subject to child protection services, but they knew the youth care worker from previous child protection involvement, which may have influenced their responses. This fact underscores the need for youth care workers to carefully navigate relationships, particularly when prior involvement may lead to reluctance or aversion to intervention.

The need for tailored intervention is reflected by the varying scores between families, particularly in terms of recognising the intervention's working elements and appreciation of the youth care worker and the intervention. An explanation for Family 1's lower scores has already been noted, but their case also highlights that the intervention's effects should not be solely interpreted through subjective ratings but rather in combination with observed changes in safety and risk factors.

The fact that the working element of building a support network was least recognised by families and least applied by youth workers may reflect that this is not necessarily a family's individual need. Although the literature often reports that families with intellectual disabilities have limited social networks, previous studies have shown that they are satisfied with their networks and do not feel a need to expand them (Van Asselt-Goverts et al., 2015; Gregory et al., 2001). However, the challenges surrounding social networks in this population go beyond simple network expansion. Studies indicate that parents with intellectual disabilities often distrust professionals and the child protection system, which can make them reluctant to seek help and involve others in their family situation (Brown et al., 2022; Mayes et al., 2006). This reluctance,

coupled with a lack of knowledge about potential support, makes it difficult for professionals to facilitate the creation of supportive networks (Ailey et al., 2024; Smith & Lawrence, 2021). In line with these findings, Safe Start may need to focus not only on expanding the social network but also on strengthening existing social ties, building trust, and engaging fathers in the parenting process (Scheffers et al., 2023; Van Asselt-Goverts et al., 2015). Additionally, professionals may benefit from further training to support parents in navigating their social environments and accessing both formal and informal support networks (Dijkstra et al., 2016).

Limitations and recommendations

While Safe Start seems promising, the study has limitations, and it is essential to emphasise that this was not a study into Safe Start's effectiveness. First, the small sample size should be taken into account when interpreting the results. Although small sample sizes are common in feasibility pilot studies (Teresi et al., 2022), these findings should be considered an indication of the potential effects of Safe Start rather than conclusive evidence. Second, the study lacked a control group, so it was impossible to establish that the reduction in safety and dynamic risk was due to the intervention. Third, the study examined only short-term changes in children's safety, while we are also interested in the intervention's long-term effects.

Despite these limitations, the findings point to the potential value of further investigating its long-term effects in a larger study, preferably with a control condition. Designing controlled studies in this context might raise ethical and practical challenges, as families are often referred to Safe Start late in pregnancy, and timely support is crucial. While we acknowledge that some researchers may respectfully disagree with

this position and argue that a short baseline phase—before the child's birth—could offer valuable causal insights without directly harming the child, we want to stress the time-sensitive nature of these cases. Future studies should therefore carefully balance methodological rigour with ethical considerations, for example by comparing changes within families over time or between families receiving different levels or forms of support (dose-response research). We suggest using an active control group of families with similar risk profiles within child protection services. Such research is fundamental given the limited availability of interventions for expectant parents with intellectual disabilities where concerns about child safety are present (Zijlstra et al., 2023).

Conclusion

Acknowledging this study's limitations, it offers an initial indication that Safe Start holds promise and could mitigate safety and dynamic risks among parents with intellectual disabilities and their newborns, particularly regarding child safety. The findings of this feasibility study indicate sufficient promise to warrant studies with larger sample sizes examining whether Safe Start enhances child safety for parents with intellectual disabilities and their newborn babies compared to conventional child protection measures.





Chapter 8

The Impact of an Early Preventive Intervention on Child Safety: Evidence from the Safe Start Program

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Author contributions:
M. van Nieuwenhuijzen and B. Castro developed the study concept and acquired finances. A. Zijlstra conducted the data collection and analyses, and drafted the manuscript. M. van Nieuwenhuijzen and B. Castro supervised the research project and revised and edited the manuscript.

Abstract

Background: Risk factors for child safety can emerge prenatally, particularly in families with multiple and complex problems. The Netherlands aims to prevent children from growing up in unsafe circumstances or out-of-home placements (OOHPs), yet families often face fragmented and uncoordinated support. Integrated, timely interventions remain scarce. The Safe Start intervention was developed to provide coordinated, comprehensive support during pregnancy.

Objective: To assess whether, for families with multiple risks who are expecting a child, Safe Start improves child and parental well-being, reduces OOHPs, and lowers risk factors for child safety in the first two years of life, in comparison to child protection services before birth (CAU).

Participants and setting: A total of 149 families participated, with 13 participating in Safe Start, compared to 136 receiving CAU. Families were assigned to the intervention by either the municipality or the court.

Methods: In this longitudinal study, child and parental well-being were assessed using repeated self-report by mothers. OOHPs were determined through casefile inspection, and risk factors for child safety were measured via home visits and case files.

Results: Self-reported child and parental well-being were high in both groups. OOHPs were substantially lower in Safe Start families (15%) than in CAU families (74%). Dynamic risk factors for child safety decreased in both groups, with a slightly faster reduction in CAU. However, this difference disappeared when excluding OOHP cases.

Conclusions: The findings provide preliminary evidence that Safe Start can support expectant parents with multiple and complex problems, while keeping children safely at home.

Introduction

In recent years, increasing attention has been paid to investment in early child development (World Health Organization (WHO), 2018). The first 1,000 days of life are crucial for establishing the foundations of health, cognitive ability and socio-emotional wellbeing (Brines et al., 2022). Optimal child development requires a safe, secure and loving environment, with nurturing care and stimulation from their parents (WHO, 2018). Children who do not have the benefit of nurturing care in the first years, are at increased risk of harm later in life, such as health problems, social-, mental- and psychological problems, and learning difficulties (Barker, 2007; Norman et al., 2012). These disadvantages can continue throughout life and even into the next generation (Black et al., 2017). In some cases, an unsafe early environment can result in child protection involvement even during pregnancy and out-of-home placement (OOHP) directly after birth (Zijlstra et al., 2025), which is internationally recognized as a drastic intervention with far-reaching consequences for children, families, and society (e.g., Ainsworth & Hansen, 2012; WHO 2018).

Given the long-term consequences of adverse early experiences, it is essential to identify risks at an early stage and to provide timely and appropriate support to families at risk. International organizations, such as WHO and UNICEF, have emphasized this priority through global frameworks and policies aimed at ensuring nurturing care for all children (WHO, 2018). This study aims to examine the effects of a preventive intervention on child and parental well-being, OOHP, and risks for child's safety in the first 1,000 days.

Risk factors affecting child safety can emerge as early as the prenatal period. These factors can include maternal lifestyle, such as smoking or drug use (Blanck-Lubarsch et al., 2020; Popova et al., 2023), as well as broader circumstances, such as extreme poverty, lack of services, and social exclusion due to racial or ethnic discrimination (Sameroff, 2010). In some families, these risk factors do not occur in isolation, but rather interact with each other across multiple domains - individual factors (e.g., cognitive, psychological or psychiatric problems), social factors (e.g., limited social support, stigma or negative attitudes among professionals) and societal factors (e.g., poverty, unstable housing, and inadequate access to (health)care) (Krishnan, 2010; Van Eck et al., 2024). Families experiencing this combination of interrelated challenges are often described as 'families *with* multiple and complex problems', a term that underscores these challenges do not define the family's identity.

Among families facing multiple and complex problems, expectant parents with intellectual disabilities represent a particularly vulnerable subgroup (Zijlstra et al., 2024). They often face challenges across several domains simultaneously, leading to heightened stress for the parents (Meppelder et al., 2015; Wilson et al., 2013). Such parental stress is a key factor that can increase the risk of inadequate parenting, which may put the child's safety and well-being at risk (Aunos et al., 2008). The contextual-interactional model of Feldman & Aunos (2020) underscores that such outcomes are not simply the result of a parent's intellectual disability, but emerge from interactions of individual vulnerabilities with the broader social and environmental context. Furthermore, recent research has demonstrated that the types and combinations of difficulties encountered by these families are highly heterogeneous (Ebbers et al., 2025). This highlights that these families differ not only in their risk factors but also in their resilience, support networks, and engagement

capacities (Collings et al., 2021; IASSID, 2008). Recognizing this diversity underscores the importance of flexible, individualized, and integrated interventions that can adapt to different family profiles and complexities.

In the Netherlands, national youth and family policy is guided by the governmental ambition to ensure that children grow up safely. This ambition is further articulated in the Movement to Zero (*in Dutch: Beweging van Nul*), which aims to ensure that no child grows up in unsafe circumstances or in OOHPs or residential youth-care institutions, thereby providing a collective vision and moral compass for youth policy (Scholten, 2025). However, despite this vision, families facing multiple and complex problems – including expectant parents with intellectual disabilities – often encounter fragmented health and social care systems that fail to provide timely, coordinated and appropriate support to help them overcome the challenges that the government seeks to eradicate (e.g., Nooteboom et al., 2020; Stewart & MacIntyre, 2017). In the Netherlands, the decentralization of youth care in 2015 placed responsibility for services with local municipalities (Hilverdink et al., 2015). While this reform aimed to streamline support through the principle of "one family, one plan", evaluations show that in many cases it has resulted in fragmentation, weakened interprofessional collaboration, and led to delayed or insufficient intervention (Vanneste et al., 2022). Specifically for expectant parents with intellectual disabilities, there is a notable lack of targeted interventions during the prenatal and early childhood period, and available services often fail to provide sufficient and appropriate support (Van Nieuwenhuijzen et al., 2025; Zijlstra et al., 2023). A truly integrated approach remains largely absent.

A truly integrated approach for families facing multiple and complex problems requires coordinated, multidisciplinary collaboration across health, social and community services (Zegwaard et al., 2024). Rather than providing fragmented or sequential care, a truly integrated approach ensures that all professionals work together under a unified plan, with a coordinating professional (Van Eck et al., 2024). Such an approach actively addresses the dynamic interplay of individual, social, and environmental factors, aiming to enhance child safety, support parental competence, and promote long-term family well-being (Van Eck et al., 2024). Crucially, it adapts interventions to the unique circumstances, capacities, and strengths of each family, recognizing that parents with multiple and complex problems and intellectual disabilities require tailored, accessible, and context-sensitive support (Ebbers et al., 2025; Van Nieuwenhuijzen et al., 2025).

In line with these principles, the Safe Start (*In Dutch: Veilige Start*) intervention was developed in the Netherlands. Safe Start is a coordinating intervention designed for and with expectant parents with multiple and complex problems, including those with intellectual disabilities, to address concerns about the safety and development of the baby or the parenting skills of the expectant parents, due to multiple and complex problems. It engages parents, their social network, and professionals to jointly identify risks and strengths to create a safety plan, and to organize the necessary support to ensure a safe start for the child and prevent OOHP if possible. Based on this shared understanding, Safe Start coordinates appropriate professional support. Safe Start itself does not provide direct care or treatment, but clarifies support needs and facilitates the organization an integration of tailored help. The intervention starts during pregnancy, at 25-32 weeks gestation, and continues until six months postpartum. The aim of Safe Start is threefold: (1) To achieve

and ensure a safe environment and development for the child; (2) To enable parents to take the responsibility of parenthood, if necessary with support; and (3) If the parents are not the primary caregivers of the child, to keep the bond between parents and child intact. A more detailed description of the Safe Start intervention, including its development and implementation, can be obtained from the first author upon reasonable request. A feasibility study of Safe Start indicated that the intervention is feasible, appreciated, and promising in promoting child safety for parents with intellectual disabilities (Zijlstra et al., 2025). However, these preliminary findings highlight the need for a larger longitudinal evaluation with a control condition to investigate the actual effects of the intervention on child and family outcomes.

The present study responds to this need as a small-scale controlled longitudinal evaluation study of Safe Start for families with multiple and complex problems, including parents with intellectual disabilities. This study examines whether the Safe Start intervention benefits families, compared to comparable families in child protection services before birth. Building on the feasibility study by Zijlstra et al. (2025), we expected that (H1) self-reported child and parental well-being would improve in both groups, (H2) the rate of OOHP's would be lower among families receiving Safe Start compared to those receiving care as usual, and (H3) families receiving Safe Start would show greater reductions in risk factors for child safety than those receiving care as usual (child protection measure before birth).

Method

Study Design

The present paper reports on a predefined subset of outcome measures from an effectiveness study evaluating Safe Start. The overarching study employs a longitudinal controlled design, in which families receiving the Safe Start program are compared with families receiving care as usual (CAU), consisting of a child protection measure initiated before birth. Both the intervention and control group are followed intensively from admission to the intervention phase until two years after the child's birth. Throughout the observation period, families in both groups are contacted on a monthly basis for two years, either through home visits or brief email, Whatsapp or telephone contacts. This design results in a high number of repeated measurements per family, allowing for detailed monitoring of developmental trajectories over time. The intensive longitudinal design ensures sufficient statistical power to detect meaningful intervention effects despite modest groups sizes (Maric et al., 2015). Data were collected from multiple measurement at different time points from start intervention until two years after birth: monthly scale-questions answered by parents, in-depth interviews with parents at onset, six months-, one year-, and two years after birth, and a case-file study (case-file kept by the youth-care worker) at onset, six months-, one year-, and two years after birth.

For this paper, we used data from the monthly scale-questions to measure child and parental well-being. Information from the casefile was used to determine if the family had experienced OOHP. Finally, we used information from the in-depth interviews and the casefile to measure child safety. In Table 1, the number of participants per condition for each instrument each measurement time is presented.

Table 1

Number of participants per condition for each instrument and measurement point

	At onset	Six months after birth	One year after birth	Two years after birth
Monthly measures – child and parental well-being	Safe Start=5 CAU=5	Safe Start=8 CAU=5	Safe Start=5 CAU=4	Safe Start=2 CAU=1
In-depth interview – risk factors for child safety	Safe Start=7 CAU=3	Safe Start=6 CAU=3	Safe Start=6 CAU=2	Safe Start=5 CAU=1
Casefile study – risk factors for child safety and OOHP	Safe Start=13 CAU=136	Safe Start=13 CAU=136	Safe Start=0 CAU=136	Safe Start=0 CAU=131

Note. CAU=Care as Usual.

Intervention

- **Safe Start**

Safe Start was developed for expectant parents facing an accumulation of multiple and severe challenges that pose substantial risks to child safety, such that involvement of youth protection services is considered or already initiated. These challenges can arise from a combination of individual and contextual factors. While an intellectual disability may be one of these individual factors, it is not required for enrolment in the intervention. Participation in Safe Start is on a voluntary basis.

A youth-care worker from a child protection organization, who is trained in the Safe Start intervention, is assigned to the family. The youth-care worker coordinates the development and ongoing implementation of a structured and personalized safety plan, working closely with the parents, their social network, and professionals. This safety plan details the

actions and responsibilities of each party during each stage of pregnancy and early infancy (see Zijlstra et al., submitted, for more details on the Safe Start intervention). The youth-care worker keeps a casefile of each family.

In terms of feasibility, in a first small-scale study, parents generally recognized most of the working elements of Safe Start. Four out of five families identified between 7 and 8 elements as present, with only minor variations. One family identified fewer elements. (see Zijlstra et al., 2025 for a list of these elements). Youth-care workers rated themselves for the application of these working elements, ranging from 6.91 to 8.18 (on a 1-10 scale). Four out of five families reported that Safe Start contributed to a safe start for their child. Youth-care workers rated Safe Start's contribution to a safe start, on average, with a 6.6 on a scale of 1-10 (*SD* = 0.9, *range*: 6.0-8.0). Moreover, three out of five families rated the intervention with an 8 on a 10-point scale, the other two families gave a 1. Four out of five families rated their youth care worker with an 8 or above, and one family with a 1. Finally, four out of five families would recommend Safe Start to a friend or family member in need.

• Comparison group: Child protection measure before birth (care as usual; CAU)

Participants in the comparison group received CAU. In the Netherlands, two different child protection measures can be imposed before birth if there is a high likelihood that the child's safety will be jeopardized after birth: a Family Supervision Order and State Custody (see for more information on child protection measures during pregnancy in the Netherlands: Zijlstra et al., 2025).

With the Family Supervision Order, the parents retain custody of their child but must cooperate with the youth-care worker, and follow his/her recommendations. State Custody is imposed if the parents are not yet adults (18 years old) or if the child's safety cannot be guaranteed within an acceptable period. As a result, the parents will lose custody of their child (Person and Family Rights, 2021a, 2021b). In these contexts, the youth-care worker acts as a case-coordinator who initiates and refers to care, but does not actively coordinate the day-to-day implementation of a safety plan such as in Safe Start. Coordination primarily involves monitoring, referral, and oversight, rather than the intensive and structured coordination characteristic of Safe Start. The youth-care worker keeps a casefile of each family.

Participants

Between July 2022 and June 2024, 37 parents enrolled in the Safe Start intervention, 11 of whom agreed to participate in one or more study measurements (monthly measures; in-depth interviews; casefile study, see Measures). Seven families participated in all study measurements, and four families participated only in the casefile study. Reasons not to participate were diverse, and included the youth-care worker forgot to introduce the study, involvement of too many professionals, a preference to engage only in activities that required minimal energy and were focused on personal needs, lack of interest in the study, and cases in which no specific reasons were provided. For privacy reasons, we cannot compare parents who did participate with those who did not.

During the same period, 138 other parents were subjected to a child protection measure during pregnancy (CAU). We were able to view all their 138 casefiles because the Dutch Youth Act permits viewing files of youth with a child protection measure without active consent for

research purposes to improve quality of care (Data Processing, Privacy, and Consent, 2022). In addition, three of these families also agreed to participate in all study measurements, two in the monthly measures and casefile study. For families participating in Safe Start viewing case files without asking for consent was not possible, because Safe Start is a voluntary intervention and therefore not covered by the Youth Act in this sense. However, of the 138 CAU families, two were also enrolled in the Safe Start intervention, and three of the 11 participating Safe Start families also received CAU. Thus, the final sample size was 149 cases: 13 families received Safe Start (five of which also received CAU) and 136 families received CAU. The family demographic characteristics at onset are summarized in Table 2 for each intervention group and the total group.

Procedure

The study was approved by the ethical committee of [masked for blind review]. Parents were referred to Safe Start by their municipality in cases of serious and multiple risks to child safety, where involvement of youth protection services was considered or imminent, and comparable in severity to cases that could result in a child protection measure. Alternatively, families received care as usual (CAU) following the imposition of a child protection measure by a judge. In the Safe Start condition, this was a youth-care worker from a child protection organization trained in Safe Start, whereas in the CAU condition, this was a regular youth-care worker from a child protection organization. The youth-care worker informed parents about the study with an information letter. Interested parents gave consent to be contacted by the researcher, who provided detailed study information and obtained active consent using materials adapted for intellectual disabilities (plain language, pictograms). Prior to this study, we consulted parents with intellectual disabilities to ensure that the documents were understandable to parents with intellectual disabilities.

For each instrument and measurement point, families could indicate whether they wanted to participate, and they could stop at any time. Furthermore, after six months in Safe Start or at any time in CAU, the casefile was closed when the intervention was finished. As a consequence, the available data for each instrument and measuring point differ (see Table 1).

Measures

• Child and parental well-being

Mothers were asked the same six questions every month about how they and their child were doing, and their experiences of parenting. When the child was placed out-of-home questions about parenting were not asked. The questions were asked monthly by phone, Whatsapp, email or face-to-face, depending on the parents' preference. The questions, developed for this study in collaboration with an expert by experience, were scored on a 1-10 scale. The questions were as follows:

- How am I [mother] doing?
- How am I [mother] doing in terms of taking care of myself?
- How is my child doing?
- How am I [mother] doing in terms of taking care of my child?
- How am I [mother] doing in terms of providing structure and regularity for my child?
- How am I [mother] doing in terms of comforting my child when he/she cries

Table 2

Demographic characteristics at onset by condition

	Safe Start (*n* = 13)			
	%	***M***	***SD***	***Range***
Child gender (boy)	38.5%			
Child's mean age in days		−71	36	−167, −32
Weeks pregnant		28.4	3.4	22, 33
Mothers mean age in years		29	5.3	18, 38
Fathers mean age in years		31	8.2	17, 41

• Out-of-home placement

Out-of-home placement (OOHP) was scored from the casefile as 'yes' if the child experienced OOHP in the period from birth until the age of two. If the child was subsequently returned home, the score remained 'yes' because OOHP intervention had been implemented.

• Risk factors for child safety

Risk factors for child safety were assessed for the (unborn) child for whom Safe Start or CAU was initiated using the Actuarial Risk Assessment Tool for Youth Protection *(in Dutch: Actuarieel Risicotaxatie Instrument voor Jeugdbescherming;* hereinafter ARIJ) (Van der Put et al., 2015) at each measuring point. To complete the ARIJ, information was gathered from the in-depth interview with the parents and the casefile (Van der Put et al., 2015). The ARIJ was completed for the situation where the child lived at the measurement time (at home versus OOHP). The ARIJ is a validated measurement tool for risk- and safety assessment (Vial et al., 2020). The ARIJ consists of two components: a safety assessment (10 items) and a risk assessment (30 items). The safety assessment

CAU (*n* = 136)				Total (*N* = 149)			
%	*M*	*SD*	*Range*	*%*	*M*	*SD*	*Range*
55.1%				53.7%			
	–30	29	–176, 27		–34	32	–176, 27
	33.9	4.9	14, 40		33.6	5.1	14, 40
	28	7	14, 44		28	6.9	14, 44
	32	9.7	15, 59		32	9.5	15, 59

identifies immediate child unsafety; the risk assessment can be used to estimate the risk of future unsafety (Van der Put et al., 2015). The risk assessment is divided into static risk factors (7 items) and dynamic risk factors (23 items, see the first column of Table 3). For this study, we examined changes within each family by comparing the number of dynamic risk factors over time. The safety assessment, static risk factors and the overall risk profile were not included, as these are not sensitive to change and therefore do not offer insight into potential indications of the intervention's relevance.

Each item of the dynamic risk assessment can be scored as 'yes' (1 point), 'no' (0 points), or 'unknown' (0 points). If a dynamic risk factor was scored as 'yes' based on the information from the in-depth interview or the casefile, then a 'yes' was recorded. A dynamic risk profile is calculated by summing all dynamic risk factors, which results in the following categories: low risk (0 risk factors); low to medium risk (1-2 risk factors); medium risk (3-4 risk factors); medium to high risk (5-7 risk factors); and high risk (8 or more risk factors) (Van der Put et al., 2015).

Statistical analyses

Descriptive analyses were performed to visually inspect changes in child and parental well-being over time. For each participant, line graphs were plotted to explore overall patterns and potential trends across the measurement points. To assess whether child and parental well-being changed significantly over time, a linear mixed-effects model was performed. Additionally, descriptive analyses were conducted to examine the number of OOHP within each group (Safe Start versus CAU).

To examine changes in risk factors for child safety over the four measurement occasions a one-tailed multilevel linear growth analysis was conducted. The data were structured in long format, with repeated observations nested within participants. The model included fixed effects for time (categorial: 0 = onset intervention, 1 = 6 months after birth, 2 = 1 year after birth, 3 = 2 years after birth) to capture changes across the measurements points and intervention group (categorial: 0 = Safe Start, 1 = CAU) to investigate differences in baseline levels. The interaction between time and intervention group was included to test whether the rate of change in dynamic risk factors differed by intervention group. Random intercepts and slopes were not significant, and did not improve model fit based on the Akaike Information Criterion(AIC). Therefore, the final model included only fixed effects, assuming homogeneous change trajectories across participants.

Results

Child and parent well-being

For the 13 mothers who participated in monthly self-reports, self-reported maternal functioning (Figures 1 and 2) showed moderate variability across months. Ratings for “How is my child doing?” (Figure 3)

remained consistently high throughout the observed period, with limited variation across months. This indicates that mothers perceived their children's overall well-being as stable and positive. Scores on the parenting questions (Figures 4-6) showed steady, relatively high scores across months. Although individual variability was present, the overall pattern indicated consistent levels. No significant increase or decrease in any of the six monthly self-report outcomes was observed over time.

Figure 1

How am I [mother] doing?

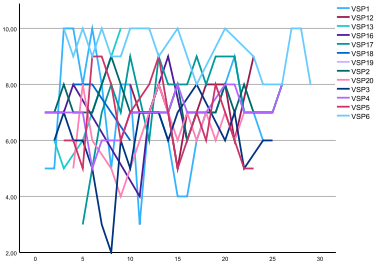


Figure 2

How am I [mother] doing in terms of taking care of myself?

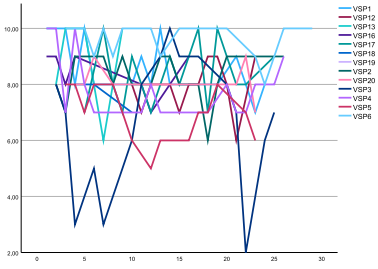


Figure 3

ow is my child doing?

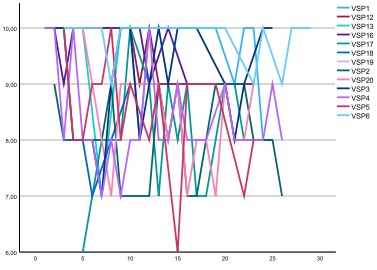


Figure 4

How am I [mother] doing in terms of taking care of my child?

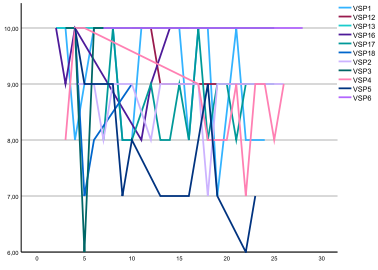


Figure 5

How am I [mother] doing in terms of providing structure and regularity for my child?

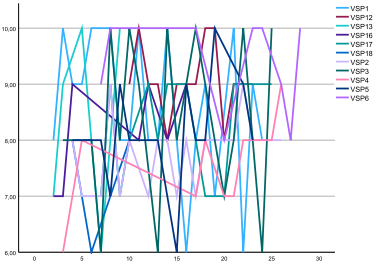
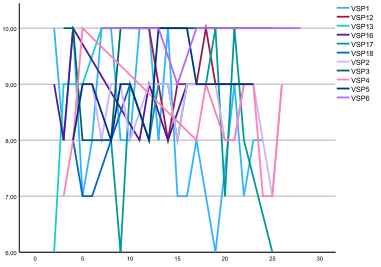


Figure 6

How am I [mother] doing in terms of comforting my child when he/she cries?



Out-of-home placement by group

Out of home placement was significantly lower in the Safe Start group than in the CAU group, X^2 (1,N=596)=59.00, p< .001. During the observation period, from birth until two years of age, out-of-home placement occurred in 15% (n = 2) in the Safe Start group, whereas 74% (n = 101) of the children in the CAU group experienced placement.

Risk factors for child safety by group at onset

To illustrate the presence of dynamic risk factors, Table 3 shows the percentage of each dynamic risk factor present each measuring point for each group. In both groups, most risk factors showed their highest prevalence at onset and decreased over the two-year period. Visual inspection suggests several differences between the Safe Start and CAU groups. At onset, families receiving Safe Start were having higher levels of physical violence against the child, domestic violence, high levels of family stress and parental anger dysregulation. In contrast, at onset the CAU group showed higher rates of neglect, emotionally absent caregiver(s),

as well as higher tendency among caregiver(s) to view identified parenting problems as less serious than the youth-care worker, and substantially lower parental willingness or ableness to change.

Risk factors for child safety by group over time

In comparing these trajectories, it is important to note that the risk factors in the families with OOHP pertain to risks in the placement families, and that far more families in the CAU group (74%) were placed out of home than in the Safe Start group (15%). This implies that for the later measurement occasions on the trajectories predominantly own Safe Start families are compared to CAU placement families. Therefore, we examined the longitudinal trajectories of dynamic risk factors for both the full sample, and separately for the subgroup of children who did not experience OOHP during the observation period. The latter to compare child safety outcomes between children who stayed home versus children who did experience OOHP.

Table 3

Presence of the dynamic risk factors at each measuring point for each group

		Safe Start (*n* = 13)			
		1	**2**	**3**	**4**
There are facts/concrete evidence pointing to recent (= between now and three months ago)					
1.	Physical violence (against the child)	**30.8%**	0%	7.7%	23.1%
2.	Sexual abuse (of the child)	0%	0%	0%	0%
3.	Psychological violence (against the child)	7.7%	0%	0%	7.7%
4.	Neglect (of the child)	46.2%	7.7%	15.4%	7.7%
5.	Domestic violence (in the family)	**53.8%**	38.5%	23.1%	7.7%
There are concerns about:					
6.	Protection and safety	53.8%	15.4%	7.7%	0%
7.	Basic care	61.5%	7.7%	15.4%	7.7%
8.	Rules and boundaries	38.5%	7.7%	7.7%	0%
9.	Stability	84.6%	30.8%	15.4%	7.7%
Other dynamic risk factors					
10.	Caregiver(s) has psychiatric problems (e.g., anxiety problems or depression)	76.9%	69.2%	53.8%	38.5%
11.	Caregiver(s) has addiction problems related to substances	61.5%	23.1%	15.4%	15.4%
12.	Caregiver(s) is physically absent	7.7%	0%	7.7%	7.7%
13.	Caregiver(s) is emotionally absent	38.5%	30.8%	38.5%	23.1%
14.	Caregiver(s) has a problematic partner relationship	76.9%	53.8%	46.2%	23.1%
15.	There are many conflicts between family members	30.8%	7.7%	38.5%	30.8%
16.	Caregiver(s) is in social isolation or caregiver(s) has many social conflicts	46.2%	38.5%	23.1%	23.1%
17.	Caregiver(s) has stress due to material and/or financial problems (e.g. unemployment, debt or homelessness)	46.2%	30.8%	15.4%	15.4%
18.	Caregiver(s) experiences stress in the family (due to divorce or illness, for example)	**92.3%**	46.2%	30.8%	15.4%
19.	Caregiver(s) is dominant (strict, unjust and/or overly controlling parenting behavior)	15.4%	15.4%	7.7%	7.7%

CAU (*n* = 136)				Full sample (*N* = 149)			
1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
8.1%	0%	0%	0%	10%	0%	0.7%	2%
1.5%	0%	0%	1.5%	1.3%	0%	0%	1.3%
2.9%	0%	0.7%	0%	3.4%	0%	0.7%	0.7%
64%	14%	11%	5.9%	62.4%	13.4%	11.4%	6%
37.5%	9.6%	2.9%	2.2%	38.9%	12.1%	4.7%	2.7%
58.8%	8.8%	11.8%	2.9%	58.4%	9.4%	11.4%	2.7%
64%	8.1%	8.1%	2.2%	63.8%	8.1%	8.7%	2.7%
33.8%	8.1%	8.8%	5.1%	34.2%	8.1%	8.7%	4.7%
86%	27.9%	18.4%	14%	85.9%	28.2%	18.1%	13.4%
79.4%	32.4%	13.2%	8.8%	79.2%	35.6%	16.8%	11.4%
52.9%	14.7%	8.1%	3.7%	53.7%	15.4%	8.7%	4.7%
11%	0.7%	0.7%	2.9%	10.7%	0.7%	1.3%	3.4%
52.2%	7.4%	9.6%	7.4%	51%	9.4%	12.1%	8.7%
71.3%	21.3%	16.9%	8.8%	71.8%	24.2%	19.5%	10.1%
39.7%	13.2%	7.4%	10.3%	38.9%	12.8%	10.1%	12.1%
56.6%	16.2%	15.4%	6.6%	55.7%	18.1%	16.1%	8.1%
42.6%	19.9%	11.8%	3.7%	43%	20.8%	12.1%	4.7%
56.6%	22.8%	16.9%	14.7%	59.7%	24.8%	18.1%	14.8%
5.1%	1.5%	0%	3.7%	6%	2.7%	0.7%	4%

		Safe Start (*n* = 13)			
		1	**2**	**3**	**4**
20.	Caregiver(s) insufficiently regulates own anger	**84.6%**	46.2%	38.5%	7.7%
21.	Caregiver(s) view identified parenting problems as less serious than the social worker	38.5%	30.8%	15.4%	7.7%
22.	Caregiver(s) is insufficiently willing and/or able to change own (parenting) behavior	30.8%	23.1%	15.4%	7.7%
23.	Caregiver(s) perceives child as problem	0%	0%	0%	0%

Risk factors for child safety by group over time

In comparing these trajectories, it is important to note that the risk factors in the families with OOHP pertain to risks in the placement families, and that far more families in the CAU group (74%) were placed out of home than in the Safe Start group (15%). This implies that for the later measurement occasions on the trajectories predominantly own Safe Start families are compared to CAU placement families. Therefore, we examined the longitudinal trajectories of dynamic risk factors for both the full sample, and separately for the subgroup of children who did not experience OOHP during the observation period. The latter to compare child safety outcomes between children who stayed home versus children who did experience OOHP.

- **Full sample**

A one-tailed growth multilevel linear analysis was conducted to examine changes in the number of dynamic risk factors over four time points (onset, 6 months-, 1 year-, and two years after birth) and to compare these between the intervention groups (Safe Start versus CAU). A linear model with fixed and random effects was first fitted to the data. No significant

CAU (*n* = 136)				Full sample (*N* = 149)			
1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
69.9%	17.6%	14.7%	9.6%	71.1%	20.1%	16.8%	9.4%
69.9%	12.5%	14%	4.4%	67.1%	14.1%	14.1%	4.7%
78.7%	13.2%	13.2%	4.4%	74.5%	14.1%	13.4%	4.7%
0%	2.2%	0%	0%	0%	2%	0%	0%

random effects were detected, as model comparison using Akaike's Information Criterion (AIC) indicated that the model without random effects provided a better fit. Therefore, the random effects were omitted from the final model. The final model included Time, Intervention Group (Safe Start or CAU) and their fixed effects (AIC = 3045.05). The outcome variable was regressed on time, intervention group, and their interaction.

In Table 4, the fixed effects estimates are represented. No significant difference was found in the intercept between groups, indicating that the groups did not differ in their baseline number of dynamic risk factors (Safe Start: 10.23 (high risk profile); CAU: 10.43 (high risk profile)). Thus, the groups start at a similar level of dynamic risk factors. There was a significant negative effect of time, indicating that the number of dynamic risk factors decreased in both groups. The interaction effect between time and intervention group was significant, indicating that the rate at which risk factors decreased over time was greater in the CAU group than in the Safe Start group. On average, the number of dynamic risk factors two years after birth was 4.63 (medium to high risk profile) in the Safe

Start group – which predominantly consisted of own families (85%) - and 1.31 (low to medium risk profile) in the CAU group (see Figure 7) – which by that time consisted mainly of placement families (74%).

• Sample of children who did not experience OOHP

To prevent comparing actual families with placement families, the same analysis was conducted for the subset of families in both groups who did not experience OOHP in the observation period. In Table 4, the fixed estimates are represented. The results differ from the full sample, because the interaction effect between time and intervention group was not significant. As can be seen in Figure 7, the difference between the two groups in the average number of dynamic risk factors two years after birth is smaller than in the total group: in the Safe Start group without OOHP the average number of dynamic risk factors is 5 (medium to high risk profile) and in the CAU group without OOHP the average number is 3.68 (medium risk profile).

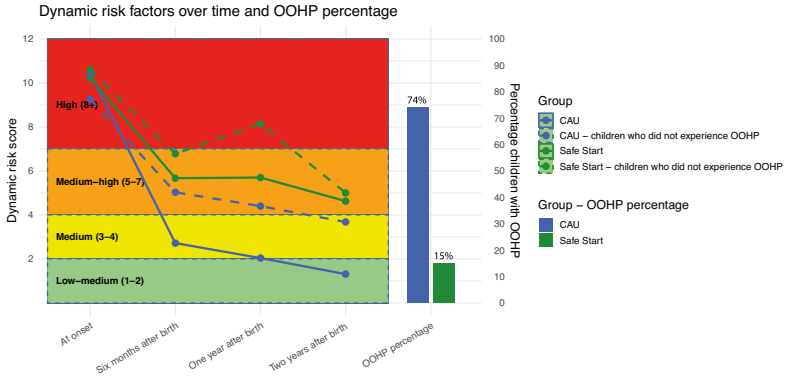
Table 4

Results of the linear growth analysis for child safety

	Estimate	*SE*	*t*	*p*	95% CI
Full sample					
Intercept	10.34	1.06	9.74	<.001	8.24, 12.44
Time	–1.35	0.37	–3.64	<.001	–2.09, –0.62
Intervention group	–0.10	1.11	–0.09	.466	–2.28, 2.09
Interaction effect: time x intervention group	–0.85	0.39	–2.20	.015	–1.61, –0.09
Children who did not experience OOHP					
Intercept	11.06	1.22	9.05	<.001	8.59, 13.53
Time	–1.58	0.49	–3.25	.001	–2.56, –0.59
Intervention group	–1.81	1.37	–1.32	.097	–4.57, 0.95
Interaction effect: time x intervention group	–0.14	0.54	–0.26	.398	–1.23, 0.95

Figure 7

Number of dynamic risk factors over time and percentage of OOHP



Discussion

This study examined the impact of Safe Start, a new preventive intervention for expectant parents facing multiple and complex problems, including those with intellectual disabilities, where child safety is at risk. Families who received Safe Start were compared to families who received child protection measures before birth (CAU). Both groups were followed from onset until two years after birth. We found that self-reported child and parental well-being did not change in either group; maternal well-being varied across months, while child and parental experiences remained high. The results concerning self-reports were in contrast to our hypothesis. Consistent with our hypothesis, we found that the rate of OOHP was much lower among families receiving Safe Start (15%) than among to families with a child protection measure before birth (74%). Moreover, dynamic risk factors decreased in both groups. However, depending on the exact comparison we made, the rate

of decrease was greater in the entire CAU that consisted mainly of placement families than in the entire Safe Start group that consisted mainly of original families. This difference disappeared when we only compared original families in both groups, by excluding OOHP cases. These results suggest that with Safe Start it is possible to significantly reduce the number of OOHP, even if the number of dynamic risk factors may decrease less rapidly.

These findings highlight a central tension: reducing OOHP appears achievable even when some risks for child safety remain. In a sense, the much lower rate of OOHP among Safe Start families that protects children form the risk of OOHP itself, comes at the cost of a smaller reduction of other risks. This raises an important question about how we balance safety, prevention, and family preservation. This question touches a core dilemma in preventive child welfare: weighing the risks of children remaining at home against the risk associated with out-of-home placement. Remaining at home in an unsafe parenting situation not only predicts future unsafety for the child (White et al., 2015), but is also linked to poor developmental, behavioral, and health outcomes across the lifespan (e.g., Stoltenborgh et al., 2020). At the same time, it is well established that OOHP also carries substantial risks, including risks for higher levels of internalizing problems, poor educational and behavioral outcomes, and overall, does not improve the opportunities of children later in life (e.g., Hansen & Ainsworth, 2011, Orri et al., 2021). From these perspectives, there is a clear need for interventions that allow children to safely live at home, provided that timely intervention takes place and the situation is closely monitored. This need is especially urgent in the first 1,000 days of a child's life, when attachment processes are particularly sensitive and foundational (WHO, 2018). Within these complex balancing acts, Safe Start appears to offer a promising pathway by

reducing the number of OOHP while supporting families in addressing risks before they escalate.

Nonetheless, decisions about whether families can be safely supported through voluntary interventions or require mandatory child protection measures remain complex. One of these complexities is that the parental's decision to participate in voluntary interventions might be influenced by the knowledge that refusing to cooperate may lead to child protection measures. However, the presence of this external pressure can heighten awareness of the seriousness of the situation. At the same time, the absence of a mandatory child protection measure allows space for collaboration and trust-building (Shah et al., 2019). Recent meta-analytic evidence further complicates these decisions by showing that, although mandatory child protection measures are necessary in certain situations, they are not consistently associated with improved outcomes for children and families across studies and contexts (Sterenborg et al., 2025). The results of the current study contribute to this discussion, by demonstrating that decreases in dynamic risk factors were greater among children whose families received mandatory child protection measures. Yet, when only children who remained at home were considered, risk reductions were similar for families participating in the voluntary Safe Start intervention and those under mandatory child protection measures. These findings suggest that while mandatory measures may accelerate risk reduction in some cases, voluntary preventive support can be equally effective in maintaining children safely at home, as only 15% of the children receiving Safe Start were placed out-of-home compared to 74% of those under mandatory measures, thereby reducing the use of OOHP considerably. This aligns with previous findings by Doelman and colleagues (2024), who reported that child maltreatment decreased under both mandatory measures and voluntary

interventions, with no significant difference in the reduction between these groups. These findings together suggest that voluntary interventions can achieve comparable outcomes to mandatory measures. Future research should further examine the conditions under which voluntary support suffices and when mandatory child protection measures are necessary to ensure child safety, particularly in families with multiple and complex problems.

Building on these insights, it is useful to interpret the findings of this study in relation to the central aim of the Dutch government: keeping children safely at home. First, the absence of change coupled with high self-reported scores on child well-being and parenting experiences can be considered positive, because these questions were primarily asked to parents whose children lived at home (11 out of 13 lived at home during the research period). However, the high scores may also be due to mothers evaluating their child's well-being, and their own parenting experiences more positively than external observers. It is also possible that mothers were cautious in their answers, fearing child protection measures or an OOHP. However, this does not seem to be entirely the case, as mothers were honest about their own well-being and gave this lower scores. Even though the child well-being and parenting experiences remained stable over time, with no significant changes reported by mothers, the intervention, Safe Start or CAU, may still help families effectively manage risks, allowing children to remain safely at home, as suggested by the risk and OOHP measures.

Second, that far more children remained at home in Safe Start than in families with a child protection measure may be explained by several factors. The voluntary nature of the intervention, which – as noted earlier – promotes collaboration between youth-care workers and parents

and allows for trust-building and joint problem solving (Shah et al., 2019). Moreover, Safe Start is preventive and intensive, allowing youth-care workers to engage early and address risks before they become critical (Dodge, 2019). Furthermore, as reported by youth-care workers themselves, OOHP is a more immediate and readily available option within mandatory child protection contexts. In contrast, within voluntary interventions, requesting an OOHP is more complex, which encourages creative solutions and reinforces collaboration with parents. Together, these explanations suggest that the lower rate of OOHP among Safe Start families reflects both the preventive, voluntary approach and the ability to keep children at home.

While the lower rate of OOHP in Safe Start suggests that children are more likely to remain in their home environment, the question remains: are they safely at home? To address this, we turn to the findings on dynamics risk factors. Although Safe Start families experienced fewer OOHPs, both groups showed significant decreases in risk factors over time. Interestingly, the reduction appeared stronger on average when including all CAU families, including those who were OOHP during the study. At first glance, this might suggest that mandatory child protection measures are more effective in mitigating risks. However, this difference largely reflects the use of OOHP. When considering only children who remained at home, risk reduction was comparable across groups. The ARIJ is completed for the environment in which the child lived, so when a child is placed in a foster family, the ARIJ reflects the risk factors of that foster family, which can exaggerate the perceived reduction in risk. In other words, the stronger decrease does not necessarily indicate that the family situation has improved, but rather that the child is no longer exposed to the same risks at home. Another possible explanation is that voluntary interventions like Safe Start may require more time to

reduce risks within the family. Importantly, the initial risk profiles were comparable between groups, indicating that we are not simply comparing higher-risk CAU families with lower-risk Safe Start families. This highlights that, even when children remain at home, risk reduction is achievable, but may proceed more gradually under voluntary support. These findings underscore the need for longer follow-up periods to fully capture the effects of preventive interventions and to ensure that children can not only remain at home, but do so safely.

Limitations

The findings of this study highlight the complexity of interpreting risk reduction and enhance our understanding of how voluntary and mandatory interventions help keep children safely at home. However, the relatively small sample of families in the Safe Start condition (n = 13) compared to the CAU condition (n = 136) and the quasi-experimental design limit the certainty with which we can conclude that Safe Start leads to fewer OOHPs. This imbalance reduces the statistical power of the analyses. The observed trends in this data provide preliminary evidence, suggesting that voluntary preventive support may help keep children safely at home. Future research should aim to include larger, more balanced samples across intervention conditions to more robustly examine the effectiveness of Safe Start.

A second limitation is that our measure of risk factors for child safety relied solely on the ARIJ, which primarily captured parental, parenting and family-related risk factors. Consequently, we lack information on child-related outcomes, such as child development and well-being. This is particularly relevant in the light of recent meta-analytic evidence showing that child protection measures do not consistently lead to improved child outcomes (Sterenborg et al., 2025). In addition, the ARIJ

does not include OOHP, even though it is a significant risk factor. Furthermore, the risk factors of the ARIJ do not capture underlying mechanisms or protective processes that may influence child safety. We also lack information on how parent-child interactions, attachment and family functioning evolve over time, limiting our understanding of why risks decrease and which components of supports are most effective. To fully understand the effectiveness of Safe Start compared to mandatory child protection measures, future research should examine child-related outcomes alongside parental, parenting and family-related factors, enabling a more comprehensive assessment of whether children not only remain at home but also develop safely.

A third limitation is also related to the ARIJ and concerns the way dynamic risk factors were assessed when children were placed out-of-home. In cases of OOHP, the ARIJ was completed for the child's new living environment. As a result, reductions in risk factors reflect the safer and more structured context of foster care, rather than genuine improvements in the caregiving conditions of the parents. This creates asymmetry in the data: risk scores decline because the child has moved to a safer environment, not because the original risks within the family have diminished. Consequently, comparisons between Safe Start and CAU must be interpreted with caution, as the stronger reductions observed in CAU may overestimate actual change in the parental home. To address this concern, we also examined risk reduction only among children who remained at home, and in this subsample the differences between groups disappeared. Even so, future research should consider parallel assessments of both the foster care environment and the parental home to more accurately capture risk trajectories across settings.

Other limitations were related to the design of this study. Families were not randomly assigned to Safe Start or CAU, which means that unmeasured differences between groups may have influenced the outcomes. Although the risk profiles were comparable at baseline, factors such as parental motivation, engagement, or practitioner decision-making may still have shaped the allocation to voluntary or mandatory support. However, the fact that we used an active control group (rather than a passive waiting list condition) is a clear strength, by testing whether Safe Start has added value over CAU. Another limitation related to the design is that the follow-up period of two years after birth might have been too short, as some changes in parenting, child development or household dynamics may require more time to manifest, particularly in voluntary interventions where improvements may unfold more gradually. Longer term follow-up is needed to understand whether risk reductions under Safe Start continue, strengthen, or diverge from those observed under mandatory child protection measures.

A final limitation is related to the broader context in which Safe Start and CAU were implemented. Regional differences in service availability, professional workloads, local policies, and collaboration between organizations may have shaped both the delivery and outcomes of the interventions. In particular, Safe Start was only implemented in the south and eastern region of the Netherlands, whereas CAU was implemented throughout the country. These contextual differences limit the generalizability of the findings, but they also point toward important implications for practice.

Implications for practice and research

The substantially lower rate of out-of-home placements among families receiving Safe Start suggests that differences in how risks are assessed and responded to may play an important role in preventing placement.

Safe Start is designed as a coordinated preventive intervention, and although the present study did not directly examine coordination or collaboration processes, the findings point to the relevance of how preventive support is organized and delivered in practice. The effectiveness of preventive interventions, such as Safe Start, depends on strong local collaboration between maternity care, youth care, mental health services and child protection services. Strengthening these networks can improve the ability to provide timely support, enabling professionals to identify emerging risk early, tailor interventions to family needs, and respond proportionally. In this way, the use of OOHPs can be limited, while children are supported to safely remain in their home environment. Equitable access to intensive, early preventive interventions across regions is therefore essential.

Safe Start provides first indications that these goals are achievable within the complex child welfare landscape. In this first small-scale study, Safe Start not only contributes to minimizing OOHPs, but also supports reductions in dynamic risk factors. This suggests that Safe Start may effectively support expectant parents with multiple and complex problems, including parents with intellectual disabilities, while keeping children safely at home. Previous research has highlighted a significant gap in services for this population (Zijlstra et al., 2024). Safe Start seems to fill this gap by providing a structured, evidence-informed, and relationship-based approach to early prevention. Policy-makers should consider supporting voluntary, intensive interventions like Safe Start as a first-line approach for expectant parents with multiple and complex problems, to promote child safety and family preservation.

Building on these practical implications, the findings also highlight the importance of ongoing monitoring and evaluation. Future research

should systematically track both family-level risk factors and child-related outcomes to determine whether Safe Start achieve their intended goals over time. Longitudinal follow-up is particularly important in voluntary frameworks, where risk reduction may unfold more gradually. Additionally, future studies would benefit from expanding the sample to include families who are directly observed and interviewed, rather than relying predominantly on casefile data. This approach can provide richer insights into family dynamics, parenting practices, and child experiences, offering a more comprehensive understanding of the intervention's impact and underlying mechanisms. Such research will inform decisions about when voluntary support suffices and when more intensive or mandatory child protection measures are necessary to safeguard child safety.

Conclusions

This study provides first tentative evidence that Safe Start may effectively support expectant parents with multiple and complex problems, including parents with intellectual disabilities, while keeping children safely at home. Although with one of the two data analytical strategy reductions in dynamic risk factors were somewhat smaller than in families receiving mandatory child protection measures, the participating Safe Start families demonstrated that risk could in most cases be managed without resorting to OOHP. These findings suggest the potential of voluntary interventions to fill critical gaps in existing child welfare services and to provide tailored support to families with multiple and complex problems during the first 1,000 days.



Chapter 9

General discussion

Like all parents, parents with intellectual disabilities generally aim to offer their children a safe, loving, and healthy start in life. Research shows that, with appropriate and tailored support, many parents with intellectual disabilities can provide "good enough" parenting and promote positive developmental outcomes (e.g., Collings and Llewellyn, 2012; Guénoun et al., 2025; Koolen et al., 2020). However, for some children of parents with intellectual disabilities, a combination of commonly experienced risk factors by parents with intellectual disabilities may challenge a successful start in life (e.g., Aunos et al., 2008; Beltran-Arreche et al., 2025; Meppelder et al., 2015; McConnell et al., 2021; Feldman & Aunos, 2020). These risks are not inherent to the intellectual disability itself, but arise from a combination of individual, relational, and contextual factors (Feldman & Aunos, 2020). Pregnancy is a critical window for identifying such risks early and providing preventive support (Lawler et al., 2015). However, in practice, risks among expectant parents with intellectual disabilities are often identified at a late stage, sometimes only around or after birth, when concerns about child safety have already intensified and may result in intrusive child protection measures (St-Laurent et al., 2019; McConnell et al., 2006). Given the limited empirical knowledge about risk factors during pregnancy in this population

(Lightfoot & Slayter, 2014), and the scarcity of tailored preventive interventions (Glazemakers & Deboutte, 2013; IASSID, 2008), there is a clear need for timely, evidence-based support. To this end, the new preventive intervention Safe Start was developed for expectant parents with intellectual disabilities where there are concerns about child safety.

This thesis aimed to gain insight into the risk factors expectant parents with intellectual disabilities experience during pregnancy in relation to child safety, reviewing the voluntary and mandatory interventions available for this group, as well as examining the feasibility and effectiveness of the Safe Start intervention. In pursuit of these aims, six studies were conducted, which together form the core of the present thesis. This final chapter highlights the main findings of these studies and describes theoretical and practical implications as well as directions for future research. To this end, the main insights supported by this thesis are first summarized.

Child safety outcomes in parents with intellectual disabilities reflect accumulated risks associated with the intellectual disability, rather than the disability itself

Previous research has consistently shown that parenting outcomes among parents with intellectual disabilities are not determined by the intellectual disability itself, but rather by the accumulation of multiple and complex problems across multiple life domains associated with the intellectual disability (e.g., Meppelder et al., 2015; Wilson et al., 2013). The present thesis confirms this finding for expectant parents with intellectual disabilities in child protection, with a specific focus on child safety outcomes (Chapters 3 and 4).

Study 1 (Chapter 3) demonstrates that these parents face a variety of risk factors in several life domains already during pregnancy, such as medical problems of the child, parental mental and health issues, neglect and abuse of other children, relationship problems, financial and housing issues, limited social network, and avoidance of care. Importantly, it is the accumulation and interaction of these risk factors, rather than the intellectual disability itself, that poses the greatest threat to the child's safety. These results can be understood in light of Bronfenbrenner's ecological systems theory (1979), which posits that parenting and child outcomes are shaped by the interactions across multiple nested systems, from the immediate family context to broader social and institutional structures. These findings also align with cumulative and transactional risk models (Sameroff, 2000), which emphasize that risk and protective factors interact dynamically over time. From these perspectives, the presence of multiple, co-occurring risk factors across ecological domains increases vulnerability and can reduce families' capacity to adapt to the demands of parenthood. Accordingly, preventive interventions should be grounded in an ecological and transactional approach, addressing multiple life domains rather than focusing on intellectual disability as an isolated characteristic. Moreover, interventions should acknowledge that changes in one domain may influence functioning in others.

Study 2 (Chapter 4) further supports this conclusion by illustrating that it is the pattern and accumulation of risks, rather than the intellectual disability per se, that differentiate child protection trajectories among expectant parents with intellectual disabilities. Specifically, three clusters based on risk factors were identified: (1) families headed by parents with intellectual disabilities, (2) single mothers with a limited social network; and (3) families with multiple and complex problems. Escalation to

state custody was more strongly associated with clusters 2 and 3, which were characterized by cumulative adversity and social vulnerability, than with cluster 1, in which intellectual disability was the most salient characteristic. These findings further emphasize that "one-size-fits-all" interventions are inadequate for this population, underscoring the necessity of tailored interventions to address the varied needs and risk factors of parents with intellectual disabilities (Lightfoot & Slayter, 2014).

Preventive interventions are crucial

In addition to the need for interventions that are responsive to the specific risk factors within families, the findings of this thesis permit a second conclusion: interventions must be implemented at an early stage to prevent the escalation of child safety problems. In Study 1 (Chapter 3), it was observed that risk factors for child safety after birth were already present during pregnancy. This finding emphasizes that risks are already evident before birth, so delaying support until after birth increases the risk of problems escalating to acute child safety measures (Potvin et al., 2020). Furthermore, Study 4 (Chapter 6) shows that voluntary and tailored interventions are preferred internationally and are generally better accepted by parents than mandatory interventions. Here too, the findings emphasize that early, voluntary support is crucial for ensuring child safety (O'Keeffe & O'Hara, 2008; Slayter & Jensen, 2019).

Despite this, Study 3 (Chapter 5) shows that the current availability of preventive interventions for parents with intellectual disabilities during pregnancy and the first two years after birth is scarce. Study 3 shows that current interventions often focus only on some of the components of "good enough" parenting, are not fully adjusted to the needs of parents with intellectual disabilities, and have rarely been evaluated for effec-

tiveness. Nevertheless, the limited evidence from the included studies in this scoping review suggests that, even interventions targeting only some components of "good enough" parenting, can produce significant and socially relevant improvements in parenting skills, with positive implications for child development and well-being. This demonstrates that early, targeted support can have a substantial societal impact (IASSID, 2008; Feldman & Aunos, 2020).

The preventive intervention Safe Start provides a concrete example of how early, voluntary, and tailored support can work in practice. Study 5 (Chapter 7) found that Safe Start was not only feasible and appreciated by parents but also associated with decreases in safety and dynamic risk factors. Study 6 (Chapter 8) confirmed this decrease in risk factors in a larger sample with a comparison group, showing that families who received Safe Start had a lower chance of out-of-home placement than families who received regular child protection measures before birth. These results illustrate that Safe Start can not only reduce risk factors but also yield concrete improvements in child safety and family outcomes, even in families with intellectual disabilities facing multiple and complex problems.

Parents with intellectual disabilities can be effectively supported to provide "good enough" parenting

Building on the findings of the individual studies, and illustrated by the Safe Start intervention, this thesis supports the idea that many parents with intellectual disabilities, when adequately supported, are often capable of providing "good enough" parenting even when they face multiple and complex problems. In line with the well-known principle that *it takes a village to raise a child*, the findings underscore that parenting is

never an individual endeavor. Like all parents, parents with intellectual disabilities need support in raising their children, sometimes only slightly more intensive or sustained. The results show that when parents with intellectual disabilities facing multiple and complex problems receive timely, appropriate, and sustained support – whether offered voluntarily or, when necessary, mandatory – the accumulation of risks can be mitigated. Of course, voluntary support is preferred over mandatory intervention. The Safe Start intervention exemplifies this broader conclusion by showing that early, tailored support can reduce the likelihood of crisis-driven child protection responses and lower the risk of out-of-home placement, even in families who still face significant challenges.

Taken together, these findings challenge historically rooted, deficit-oriented assumptions about parents with intellectual disabilities (Aunos et al., 2020; Beltran-Arreche et al., 2025) and align with a broader societal shift towards a support-oriented and contextual paradigm, in which parenting capacity in parents with intellectual disabilities is understood as conditional, developable, and strongly shaped by the availability of appropriate support. Therefore, this thesis highlights that early, appropriate support does more than prevent harm: it enables parents with intellectual disabilities, together with their wider support network, to provide a safer and more nurturing start for their children.

Limitations and strengths

Several limitations should be taken into account when interpreting the results of this thesis. First, the generalizability of the results is limited. The studies focus on a very specific population: expectant parents with intellectual disabilities who are already known to care services or child protection services and who often face multiple and complex problems. Moreover, the nature and extent of the risk factors experienced can vary

between families (as seen in Study 1 and 2), which may have affected the differences in outcomes and results between families. As a result, the findings may not be generalizable to all parents with intellectual disabilities, particularly those who are not in contact with formal support systems. In addition, the studies were conducted within a specific national context, which may limit the transferability of the findings to other countries with different welfare, healthcare, and child protection systems. At the same time, parents with intellectual disabilities who came in contact with care services or child protection services are precisely those who are most likely to experience cumulative risks and adverse outcomes, yet they remain underrepresented in empirical research. By focusing on this subgroup within a clearly defined policy and practice context, this thesis contributes essential knowledge about a population that is frequently discussed in policy and practice, but rarely examined in depth.

A second limitation concerns the primary outcome child safety used across the studies. The primary focus on child safety may be seen as restrictive, as it does not capture broader domains such as child development, family functioning or parental well-being, nor does it measure whether parents are capable of providing "good enough" parenting in line with the fourteen conditions, as defined by Zijlstra et al. (2012). In addition, child safety was operationalized through the assessment of risk factors, while protective factors and family strengths were not systematically examined. Nevertheless, this focus reflects both the preventive aims of the studies and the realities of decision-making in child protection context, where child safety is often the dominant concern. Moreover, given the early timing of the interventions studies, many child developmental outcomes were not yet measurable reliably. From both a preventive and ethical perspective, child safety therefore constitutes

a defensible primary outcome, as ensuring safety forms the first and essential condition under which development can take place. Notwithstanding, risk factors may be offset by protective factors, and it is therefore recommended that follow-up research also identify protective factors in these families.

Third, an important methodological limitation of Studies 1, 2 and 6 – the results of which underpin several of the core conclusions of this thesis – is that data were largely derived from case file analyses. This reliance on case files may limit the depth and richness of the data, as case files primarily contain information that professionals deemed relevant for decision-making, rather than capturing the lived experiences, perceptions, or strengths of parents. Consequently, certain aspects of family life, parenting strategies, or contextual factors may be underreported or entirely absent, and reporting biases may arise if professionals interpret or prioritize information differently. Although we intended to include more direct information from parents themselves, particularly in Study 6, participation was lower than expected, leaving case files as the most complete source of information available. At the same time, case files offer valuable insights into the information professionals rely on when assessing risks and making decisions. Nevertheless, first-hand qualitative data from parents' perspectives adds value by capturing parents' perspectives and the nuanced dynamics of everyday life.

Finally, a more specific limitation related to the studies into the feasibility and impact of Safe Start (Studies 5 and 6) is that a full randomized controlled trial was not completed, as the intended sample size could not be achieved and randomization was not feasible in this context, as the intervention was imposed by the municipality (Safe Start) or by court order (child protection measure before birth). However, the use of re-

peated measures in the form of self-reports strengthened the design, as this approach increased statistical power and enabled the examination of within-person changes over time, thereby partially compensating for the smaller sample size. At the same time, reliance on self-report measures entails inherent limitations, such as social desirability bias, recall bias, and shared method variance, which may have influenced the findings. Nevertheless, the findings from these studies provide valuable insight into the feasibility, acceptability, and preliminary outcomes of an early, voluntary and tailored intervention in a complex and hard-to-reach population. They offer an empirical foundation for future, more rigorous evaluations.

Despite these limitations, the evidence from the six studies provides nuanced understanding of the risks, needs, and opportunities for preventive interventions among expectant parents with intellectual disabilities facing multiple and complex problems, offering guidance for both policy and practice.

Implications for theory, policy, and practice

The findings of this thesis have important implications for theory, policy, and practice. Theoretically, the results support a paradigm shift away from deficit-oriented views of parents with intellectual disabilities towards a contextual and support-oriented perspective. Moreover, the findings are consistent with ecological system theory (Bronfenbrenner, 1979) and Belsky's (1984) process model, as they show how parenting capacity is shaped by both individual and contextual factors. Importantly, this thesis extends Feldman and Aunos' (2020) model, which conceptualizes parenting by parents with intellectual disabilities as a dynamic interplay between parent, child, and contextual factors. Their model emphasizes that parenting capacity is not a fixed trait of an individual,

but a process shaped by social and environmental conditions. The findings of this thesis contribute to this model by introducing an explicit temporal dimension. Study 1 shows that risk factors for child safety are often already present during pregnancy, highlighting not only which factors influence parenting capacities but also that early intervention is needed. While the precise timing and combination of interventions remain difficult to determine, these results underscore the theoretical importance of early, targeted support in understanding and promoting "good enough" parenting among this population.

From a policy perspective, these findings suggest that interventions should be implemented early on, be voluntary, and be tailored to the needs of parents with intellectual disabilities. In the Netherlands, this raises important questions about the current practice of imposing child protection measures during pregnancy, which is internationally exceptional and rests on an ambiguous legal basis (Study 4). While safeguarding the health and development of the unborn child is essential, reliance on judicial discretion without explicit statutory regulation creates legal uncertainty, may undermine the rights and autonomy of pregnant women, and may unwillingly contribute to avoidance of help seeking by vulnerable parents.

At the same time, current evidence suggests that preventive interventions for expectant parents with intellectual disabilities facing multiple and complex problems are often scarce, insufficiently adapted to parental needs, and rarely evaluated for effectiveness (see Study 3). The relatively high use of prenatal child protection measures may therefore reflect gaps in the availability, accessibility, or quality of voluntary preventive support. Policy efforts should therefore prioritize strengthening the availability and accessibility of voluntary interventions for ex-

pectant parents with intellectual disabilities facing multiple and complex problems. In addition, there is a clear need for a democratic and legal clarification of whether and under what conditions prenatal child protection measures are permissible, rather than leaving such decisions to case-by-case judicial interpretation. Finally, given that risk for child safety may already emerge during pregnancy (Study 1), policies should facilitate the timely provision of preventive interventions, ideally before 24 weeks of gestation, and invest in the systematic evaluation and quality improvement of these interventions. Together, these measures would support a more proactive, coordinated, and rights-respecting child welfare system, reduce reliance on crisis-driven interventions, and improve outcomes for children and families.

In professional practice, the findings emphasize the importance of early identification and proactive support to prevent escalation of risks. Interventions such as Safe Start demonstrate that intensive collaboration with parents and their support networks can reduce risk factors and prevent out-of-home placements (Studies 5 and 6). Practitioners are encouraged to engage parents openly and collaboratively, discuss risks transparently, and establish clear agreements on actions if risk factors escalate. Tailoring support to parental capacities and context, while respecting autonomy and promoting voluntary participation, is essential. Early identification of parents with intellectual disabilities, preferably during pregnancy, is crucial to enable timely adaptation of communication and support, and to mobilize appropriate services before risks accumulate.

At the same time, clear differentiation between interventions is needed to ensure that parents are referred to the form of support best suited to their needs. For parents with intellectual disabilities, referral to Safe

Start seems often more appropriate than to general preventive interventions, such as Nurse-Family Partnership Program (*in Dutch: Voorzorg*). These broader programs primarily focus on early prevention, supporting healthy pregnancy, early child development, and general parenting skills for the population at large, but they are not specifically tailored to parents with intellectual disabilities or multiple and complex problems. Safe Start, in contrast, combines early preventive elements with structured risk monitoring and intensive, network-oriented guidance, adapted to parent's capacities and contextual needs. Careful matching of families to the most appropriate level of intervention may help prevent escalation and reduce the need for more intrusive protective measures. By adopting these approaches, professionals may enable parents with intellectual disabilities facing multiple and complex problems to provide a more safe and nurturing start for their children, while minimizing the need for more intrusive child protection measures.

Directions for future research

Future research may build on the findings of this thesis by broadening the range of outcomes and constructs examined. While child safety is crucial and ethically a necessary outcome, future studies should also examine broader domains such as child development, parental well-being, family functioning, and relational outcomes, as well as protective factors, family strengths, and "good enough" parenting. Including these outcomes would provide a more comprehensive understanding of how risk and protective factors influence family life, and how preventive interventions contribute not only to the prevention of harm but also to positive developmental trajectories.

Methodologically, future research would benefit from more qualitative and mixed-methods research to capture how changes unfold within

families and how parents experience support over time. Although this thesis aimed to incorporate parents' own perspectives, the number of participating families was limited, restricting the depth of qualitative insight. Future studies using in-depth interviews, observations or participatory methods in combination with longitudinal quantitative data could yield richer information about mechanisms of change, perceived autonomy, and the meaning of "good enough" parenting in everyday life. Where ethically and developmentally appropriate, incorporating the perspectives of children at later stages would further enrich understanding of long-term family outcomes and intergenerational effects of early intervention. Moreover, future research would benefit from larger-scale study designs with sufficient sample sizes to allow for more robust analyses and greater inclusion of parents' own perspectives. Increasing direct data collection from parents, rather than relying predominantly on case files, would enhance depth, reduce reporting bias, and strengthen the empirical basis for conclusions. At the same time, longitudinal designs are needed to examine how risks, protective factors, and parenting capacities evolve over time, and to assess the sustainability of early preventive support. In addition, if Safe Start would be implemented more broadly in other settings in the future, a larger feasibility and implementation study could be valuable.

Conclusion

This thesis demonstrates that parents with intellectual disabilities are often capable of raising their children at home with support, even when they face multiple and complex problems, provided that they receive timely, appropriate, and sustained support. Like all parents, they do not parent in isolation but within a broader social context, and fulfilling the parenting role requires support: sometimes in the form of daycare, and sometimes in the form of intensive intervention trajectories.

Across studies, the findings show that risks to child safety are frequently present during pregnancy, underscoring the importance of early preventive interventions rather than crisis-driven responses after birth. Voluntary, tailored support can mitigate cumulative risks in expectant parents with intellectual disabilities and reduce the likelihood of out-of-home placement. At the same time, this thesis highlights significant gaps in the availability, accessibility, and evaluation of preventive interventions for this population, a situation that is particularly evident in the Dutch context, where the relatively high use of prenatal child protection measures is too often attributed to parents' disabilities, but may actually reflect limited access to timely, voluntary, and tailored support.

By challenging deficit-oriented assumptions and situating parenting with intellectual disabilities within a broader contextual and developmental framework, this research contributes to a paradigm shift toward understanding parenting capacity as conditional, developable, and strongly shaped by the timing and quality of support. Together, these findings provide a solid empirical foundation for advancing theory, informing policy, and improving practice. Ultimately, ensuring that young children are safe, supported, and able to thrive begins with giving parents the guidance and resources they need to succeed from the very start.



Appendices

Summary

Supporting today, preparing tomorrow's parents: Understanding and improving early support for expectant parents with intellectual disabilities.

Historically, parenthood among people with intellectual disabilities was shrouded in taboo and social stigma, leading to discrimination, disadvantage, and exclusion from society (Aunos et al., 2020; Beltran-Arreche et al., 2025). While such attitudes have not disappeared entirely, there has been a gradual shift in recent decades. Nowadays, society recognizes people with intellectual disabilities as full members with the same rights as other people, as articulated in The United Nations Convention on the Rights of Persons with Disabilities (2006). The Convention affirms the right to family life and parenthood for parents with intellectual disabilities, and emphasizes the responsibility of governments to ensure that parents with intellectual disabilities have access to adequate support to exercise their parenting rights. At the same time, recent research shows that raising children is often a complex challenge for parents with intellectual disabilities (e.g., Aunos et al., 2008; Beltran-Arreche et al., 2025; Meppelder et al., 2015; McConnell et al., 2021; Feldman & Aunos, 2020). However, this is not solely due to the intellectual disability itself,

but rather to a combination of risk factors that they often face and can arise at the individual, relational, and contextual levels (Feldman & Aunos, 2020). These risks may already manifest or increase during pregnancy, while sources of support for parents with intellectual disabilities are not always sufficient or available to support this crucial transition to parenthood (Lawler et al., 2015).

To provide appropriate support that does justice both to the parenting rights of parents with intellectual disabilities and to the safety and protection of the child, in-depth insight is needed into the risk factors experienced by these parents during pregnancy in relation to child safety, into existing voluntary and compulsory interventions for this target group, and into the effectiveness of a new preventive intervention for this population. This thesis examines these three interrelated issues.

The first issue concerns the nature, accumulation, and meaning of risk factors during pregnancy in relation to child safety. **Chapter 3** makes an important empirical contribution by systematically mapping which risk factors are present among expectant parents with intellectual disabilities who had already been subjected to a child protection measure before the birth, and for whom the safety of the unborn child was therefore at risk. The results of this case file study show that expectant parents with intellectual disabilities often face an accumulation of risk factors across different life domains. Specifically, risk factors within the child domain, family functioning domain, and care domain appear to be most strongly associated with child safety after birth. These findings nuance the still prevalent assumption that intellectual disability in itself explains unsafe parenting situations, and underline the importance of an ecological approach in which risks are viewed in relation to one another.

Building on these findings, **Chapter 4** describes a study that examined whether risk profiles could be identified within the population of expectant parents with intellectual disabilities who had already been subjected to a child protection measure before birth. Through cluster analysis, three profiles were distinguished: 1) families in which both parents have an intellectual disability; 2) single mothers with a limited social network; and 3) families with multiple and complex problems. This classification demonstrates that the population of parents with intellectual disabilities in child protection is heterogeneous and that different combinations of risk factors are associated with different child protection trajectories. Although the likelihood of out-of-home placement within six months after birth appeared similar across clusters, the transition from a supervision order to a custody order occurred less frequently among families headed by parents with intellectual disabilities (cluster 1) than among the other clusters. The results of this chapter therefore provide initial indications that differentiation within the target group of expectant parents in child protection is relevant for decision-making and referral to services.

Taken together, **Chapters 3 and 4** show that risk factors during pregnancy cannot be interpreted separately from the broader living context of parents. It is the accumulation of risk factors associated with the intellectual disability, rather than the intellectual disability itself, that appears to be decisive for child safety and for referral and decision-making within child protection measures. These insights also make clear that support cannot be generic for expectant parents with intellectual disabilities, but must be tailored to different risk profiles and family contexts. These chapters therefore form the starting point for the second issue, which focuses on the extent to which the existing range of interventions actually corresponds to these diverse support needs.

To understand how support can better match the diverse risk profiles of expectant parents with intellectual disabilities, it is necessary to investigate which interventions have proven effective for this target group. **Chapter 5** addresses this question by systematically mapping and critically evaluating existing preventive voluntary interventions for parents with intellectual disabilities who experience an accumulation of multiple and complex problems. The study described in this chapter shows that the current range of interventions is limited: internationally, only six preventive interventions were identified for parents with intellectual disabilities aimed at strengthening the fourteen conditions of good-enough parenting (Zijlstra et al., 2012) in the child's first 1000 days. In addition, most interventions did not integrate the following seven effective elements for adequate and effective support for parents with intellectual disabilities:

1. attention to the context and the multiple and complex problems these parents often experience;
2. early intervention, preferably already during pregnancy;
3. good working alliance;
4. professional knowledge of the rights of parents with intellectual disabilities and the rights of the child;
5. use of behaviorally oriented teaching methods, such as modeling, reinforcement, and task analysis;
6. home-based, long-term, and intensive support where necessary;
7. partnership with the family and the social network.

The quality of the studies evaluating the effectiveness of these six interventions is moderate. Nevertheless, the results of these effectiveness studies indicate that these interventions can have positive and socially relevant effects on parenting skills and child well-being. Chapter 5 em-

phasizes the need for more comprehensive and systematically evaluated preventive interventions and the importance of providing timely, voluntary, and contextually attuned support to strengthen parents with intellectual disabilities before a crisis arises.

Complementing Chapter 5, **Chapter 6** focuses on supporting expectant parents through interventions within child protection services. It describes a study examining whether and how child protection measures during pregnancy are legally possible in twelve Western countries, and compares this situation with practice in the Netherlands. This international comparative legal study shows that in most countries child protection measures before birth do not exist and the focus is on preventive voluntary interventions. In addition to the Netherlands, there are only two countries where such measures do exist and have an explicit legal basis. However, in these two countries child protection measures before birth are applied very cautiously, only a few times since their introduction. The Netherlands forms an exception: several hundred requests for child protection measures before birth are submitted and granted annually, despite the absence of an explicit legal basis. Based on the insights gained from this legal comparison, four recommendations are made for Dutch policy and practice: 1) improve the accessibility and quality of voluntary support; 2) ensure that voluntary support is genuinely voluntary; 3) create an explicit legal basis for child protection measures before birth; 4) make both voluntary and compulsory intervention possible before the viability threshold of 24 weeks. This chapter thus provides insight into international differences and offers concrete starting points to improve Dutch practice, with the aim of better aligning interventions with the support needs of parents and the safety of the unborn child.

The findings from Chapters 5 and 6 show that the existing range of interventions is still limited and fragmented, but that targeted, timely, and contextual support is promising. By combining the analysis of both voluntary preventive and child protection interventions, this part of the thesis provides important insights for both policy and practice. It also forms the bridge to the third issue: the evaluation of a new preventive intervention for this target group.

Whereas the first two issues primarily focused on the analysis of risk factors and the intervention landscape, the third issue shifts the focus towards the evaluation of an intervention in practice. It examines whether a new preventive intervention, called Safe Start (in Dutch: Veilige Start), developed with and for expectant parents with intellectual disabilities who experience multiple and complex problems and where there are concrete concerns about child safety, is feasible and effective for this target group.

Chapter 7 describes a study on the feasibility, appreciation, and initial effects of Safe Start in a group of five families. Despite the small sample, the findings are cautiously encouraging. Parents and youth care workers largely recognized the effective elements of the intervention, suggesting that the intervention is applicable within this complex context. In addition, most parents appreciated both the youth care worker involved and the intervention itself. After completion of the intervention, improvements in child safety were observed in all families. Although safety scores at baseline were already relatively low — leaving limited room for further improvement — any reduction is meaningful, as signals of unsafe situations indicate acute threats that must be addressed within 24 to 48 hours. In addition, modifiable risk factors decreased in three of the five families after the intervention. However, risks remained in the medium-

to high-risk category in most cases, showing that family situations remained complex and vulnerable despite these initial improvements. This underlines the importance of longitudinal research to determine whether the observed improvements are maintained over time and whether further reductions in risk factors occur.

To answer these questions, **Chapter 8** focuses on a longitudinal study in which the effects of Safe Start were examined in 13 families and compared with 136 families with a child protection measure before birth. Families were followed from the start of the intervention until two years after birth. Improvements in self-reported well-being of parents and children were not observed, but in both groups well-being was relatively high at baseline and remained stable over time. In contrast, a substantial difference was found in the number of OOHP between the two groups: 15% in the Safe Start group versus 74% in the group with a child protection measure before birth were placed out of home during the study period. Dynamic risk factors also decreased significantly in both groups. The decrease appeared larger in the group with a child protection measure before birth, but this difference disappeared when only families without OOHP were considered. This suggests that with Safe Start it is possible to significantly reduce the number of OOHP, even if the number of dynamic risk factors may decrease less rapidly.

Taken together, Chapters 7 and 8 show that a preventive, voluntary, and contextually attuned intervention (Safe Start) is feasible and appreciated, and is moreover associated with a strong reduction in the likelihood of OOHP. The third part of this thesis therefore provides empirical support for the perspective outlined in the earlier chapters, namely that timely and accessible voluntary support represents a promising approach alongside or instead of mandatory child protection measures.

The findings from the three issues form the basis for the discussion, in which three key insights are central. First, the studies in this dissertation show that outcomes regarding child safety are not primarily explained by intellectual disability itself, but by the accumulation of risk factors associated with the disability. Second, preventive and timely support appears crucial, precisely because risks often manifest already during pregnancy. Third, the findings suggest that parents with intellectual disabilities, even when faced with multiple and complex problems, can be effectively supported in providing "good-enough" parenting, provided that they receive appropriate and sustainable support. Taken together, the studies suggest that voluntary, tailored interventions can contribute to reducing cumulative risks and decreasing OOHPs, enabling parents with intellectual disabilities and multiple problems to care for their children at home more often with appropriate support.

At the same time, this thesis makes visible that substantial gaps exist in the availability, accessibility, and systematic evaluation of preventive support for expectant parents with intellectual disabilities and multiple and complex problems, particularly in the Dutch context. Against this background, the relatively high use of child protection measures before birth — and the overrepresentation of children of parents with intellectual disabilities within child protection — appears not merely to reflect parental disability, but rather a system in which timely and appropriate voluntary support is insufficiently accessible and available. Moreover, compared with other countries, the Netherlands makes extensive use of coercive and compulsory interventions without a solid legal basis.

By moving away from a deficit-oriented approach and understanding parenting among parents with intellectual disabilities as conditional and developable within a broader social context, this thesis supports a paradigm shift in thinking and practice: safeguarding child safety begins with providing timely and appropriate support to parents with intellectual disabilities and multiple and complex problems, from the very beginning.



Appendices

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A

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Appendices

Dankwoord

Vijf jaar later, ontelbare koppen cappuccino's en minstens evenveel conceptversies later ligt het er dan: mijn proefschrift. Wat begon met een opvallend gegeven in de data tijdens mijn stageperiode bij Expect Jeugd, veel jonge (tiener)moeders van wie de ongeboren of pasgeboren baby een kinderbeschermingsmaatregel opgelegd had gekregen, groeide uit tot een onderzoeksproject en uiteindelijk dit proefschrift.

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tijdens de coronaperiode, waren onze maandelijkse TOVS-overleggen altijd een hoogtepunt. (En eerlijk gezegd weet ik nog steeds niet precies waar TOVS voor staat...?) In die overleggen konden we alles bespreken: van de nieuwste ontwikkelingen binnen het onderzoek tot de laatste privé nieuwtjes. Na elk overleg kon ik altijd vol positieve en frisse energie verder met mijn werk. Maroesjka, ik wil je bedanken dat je tijdens mijn stage al potentie in mij zag en in mij hebt geloofd. Dankjewel dat je mij serieus nam toen ik dat opvallende gegeven in de data ontdekte, en dat je vervolgens samen met Bram het onderzoeksvoorstel bij ZonMw hielp indienen. Dank dat je als eerste weer aan mij dacht toen het onderzoek uitgevoerd kon worden. Ik ben je ook dankbaar voor je scherpe correcties op taal, maar in het bijzonder wil ik je bedanken voor je persoonlijke betrokkenheid. Van je appjes om te vragen hoe het ging met mijn zwangerschap, tot sinterklaasfeestjes bij jou thuis. Je hebt mij laten zien dat onderzoek niet alleen over data gaat, maar ook over de menselijke kant van het vak. Bram, ook jou wil ik hartelijk bedanken. Dank voor je altijd kritische blik. Je hebt mij geleerd kritisch te zijn, zonder mijn nieuwsgierigheid te verliezen. Dank voor de toevoeging van je mooie Engelse zinnen aan de manuscripten. Wat ik vooral aan je waardeer is je positiviteit. Je wist er altijd weer een positieve draai aan te geven, ook al hadden we een flinke tegenvaller, zoals dat we veel minder gezinnen hadden kunnen includeren dan oorspronkelijk beoogd. Die positieve instelling gaf mij het vertrouwen om door te zetten en het beste uit mezelf en het onderzoek te halen. Dank beiden, jullie hebben mij geïnspireerd en dit proefschrift mede gevormd.

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