Think Family, Work Family

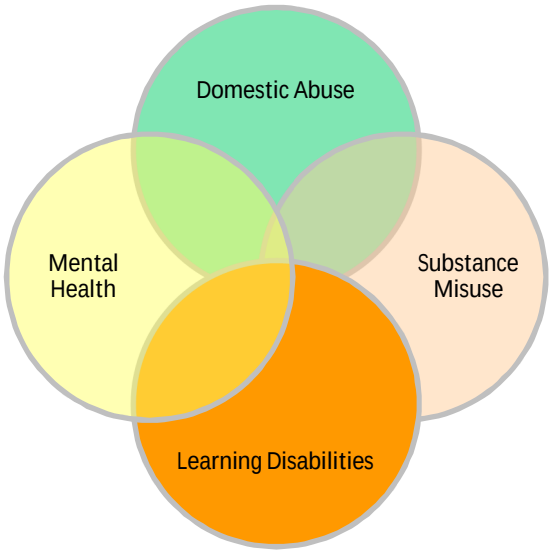
A Joint Safeguarding protocol for co-ordinating the support families receive from services working with children and adults, where parenting capacity is impacted.

Practice Guidance

Purpose of this document

The purpose of this document is to set out how services that work with adults and services that work with children can work together better to safeguard children and vulnerable adults through more joined up support to help families help each other better. It builds on existing good practice across agencies and replaces the Leeds Think Family Protocol of 2010.

The document, and the supporting protocol, is intended for all organisations that work with children, adults and families, but specifically focuses on responding to the needs of families where substance misuse, learning disabilities, domestic abuse or parental mental ill-health are evident. Children are more susceptible to risk and harm where they are living with an adult who has one of these vulnerability factors. The risk increases if more than one vulnerability factor is present, or pertains to more than one parent, although a non-affected partner can provide a protective factor.



This guide is intended for the use of frontline practitioners and managers, but will also have relevance for those commissioning services, as well as those developing policy and strategy. The protocol outlines the importance of taking a Think Family approach, and ways in which this approach can be translated into practice.

Those commissioning services should ensure that the commissioned provider is adopting a Think Family approach.

Working within a Whole Family Approach

A proportion of adults known to the mental health, substance misuse, physical / sensory and learning disability services have children. In Leeds we recognise that, common with the population as a whole, most of these parents are committed to their children and want what is best for them. The presence of additional vulnerabilities for adults as parents/carers does not automatically preclude the possibility of good parenting. It is important, therefore, that when a practitioner is working with an individual within a family, child or adult, they need to take a holistic approach. This considers the individual as a member of the family who will be affected by their behaviours and who, in turn, will have an impact on each family member. These impacts may be positive and supportive or negative. When considering any vulnerabilities or risks that they have identified practitioners should consider the support available to the individual and family from extended family and the wider community.

Think Family, Work Family – our approach

This protocol does not require complicated change or for everyone to be an expert in every facet of family life. The key elements of what children and families need is quite simple:

Safeguarding first

To ensure healthy happy families all members need to feel safe. This includes being kept safe by immediate family members, those within their wider community and services working with them. It must be remembered that in law the needs of the child are paramount and therefore any concerns about their safety and welfare must be responded to by any practitioner.

Permanency

The majority of Children (and families) want to stay with their families wherever possible, although this may be families in widest sense. Where this is safe to do so we should provide support to allow this to happen, increasing the opportunities for better outcomes. It isn't about insisting on perfect parenting, but recognising and supporting good enough parenting.

Relationships

When working with an individual child, young person or adult it is important to think of their relationships with their family and their wider context such as friends and local community. No-one exists in isolation and people can only be properly understood, and only effectively supported by understanding and working with their family and wider networks.

Relationships between the worker and the family are also important, as research shows that this relationship is key to making change.

> *"All of what we do turns on something very simple: the relationship between the worker and the family. … None of us changes because we are given a report or an analysis. We have to feel that we want to change and know how to change. The difference with family intervention is that they make people believe in themselves. … Remember the humanity in it. Forget which agency you are from, and remember the human being (Louise Casey, 2013)*

Right conversation, right people, right time

Leeds is promoting a more people focused, flexible and collaborative approach to safeguarding. The Leeds Safeguarding Children Board is advocating a shift from inflexible and mechanistic ideas of thresholds and checklists towards encouraging people and practitioners to talk more. The advantages of this approach are:

- Founded on collaboration and conversation
- Promotes shared responsibility and flexibility
- Recognises complexity of unique needs of each individual child and family
- Reduces bias of individual professional and agency decisions through debate

Restorative Practice

Restorative Practice is a key element of the Leeds approach to working with children and families. Restorative Practice is underpinned by values of empathy, respect, honesty, acceptance, responsibility, and mutual accountability and seeks to make change working on the premise that:

‘People are happier, more cooperative and productive, and more likely to make positive changes when those in positions of authority do things with them, rather than “to” them or “for” them. ‘

Restorative Practice aims to work on empowering individuals and communities to take control, and to build empathy to build better relationships. It is clear that this approach has obvious value both in working with families and in encouraging families to take control and support each other.

Therefore the Think Family, Work Family principle should be embedded within practitioners day to day work, and is reflected in a range of approaches within Leeds including the Families First Programme, Kinship Care and Family Group Conferencing.

COMMON PRACTICE GUIDANCE

The following information and guidance applies across all services working with individuals (child or adult) and/ or families.

Categories of Abuse

Working Together 2013 identifies that children and young people are potentiality at risk under four categories of abuse; Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect.

West Yorkshire Multi-Agency Safeguarding Adults Policy and Procedures identifies that Adults at Risk are potentially at risk under seven categories of abuse; Physical Abuse, Sexual Abuse, Psychological / Emotional Abuse, Financial Abuse, Neglect , Discriminatory Abuse and Institutional Abuse.

Impact on Children

Whilst the presence of issues which effect parenting capacity do not automatically place children at risk of abuse or neglect, the potential for children to have unmet needs or to be at risk of harm is increased, so it is essential to consider and assess their needs and the impact on them.

Some parents have good support networks and are able to meet their children's needs. Some are aware of the potential effect of their behaviours on their children and actively minimise it. However when this is not the case, the impact on children can be serious and long lasting. These can include:

- lack of supervision;
- lack of stimulation, guidance and boundaries;
- reduced physical care;
- increased risk of dangers in the home environment including; substances, equipment or inappropriate visitors;
- poor school attendance;
- anxiety;
- increased risk of misusing substances or alcohol themselves;
- becoming a young carer;
- emotional, behavioural and social problems for children and young people; and
- severe neglect or abuse.

Assessment of Risk and Need within Families

Working with the whole family requires a co-ordinated approach to assessment and intervention, thus protecting both children and adults at risk from harm.

Consideration of immediate risk should be prioritised as follows;

1. The welfare and safety of the child, including assessment and ensuring their views are sought (Paramount in law- Children Act 1989).

2. The welfare and safety of adults at risk who may be at risk from violence or abuse and who may or may not have capacity to make informed decisions. (No Secrets, HM Govt 2000; Mental Capacity Act, 2005).

3. Public protection – consider whether the situation presents a risk to the wider public e.g. risk of sexual offences, risk of terrorism, risk of violence (MAPPA, 2010; Prevent Strategy; HM Government, 2011).

Wherever possible duplication of assessments should be avoided in order to maximise the professional's time spent and minimise repetition and stress for the family. Professionals should consider undertaking joint visits and joint assessments.

Where domestic abuse, mental health problems, substance misuse and or learning disability are present in a family, assessment must take account of the impact on the care provided to vulnerable adults, children and young people.

When undertaking an assessment on a child or young person, or an adult where there is a child or young person in the home, these should be based on the Working Together (2013) framework triangle (or the My World Assessment Triangle in Appendix A when talking with children and young people):

When assessing the impact on children, it can be helpful to consider the following issues;

- What are the risk factors both immediate and in the longer term?
- What is the child's day-to-day experience like (considering both increases and decreases in occurrence of the identified issues)?
- What are the strengths and protective factors?
- Is the parent's behaviour likely to change? Why is this so? What will support the change? How will change be recognised?
- Are changes to parenting and not just the behaviours likely to be within a timescale that will meet the child's needs?
- Have all agencies contributed to the assessment?

When assessing the potential for a vulnerable adult to be at risk six key principles must be considered (DoH, 2013):

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

Practitioners working with any member of the family must make a judgement based on asking fundamental questions as well as using the framework tool to identify unmet need. Appendix B outlines these questions.

Practitioners should ensure that the voices of children, young people and adults at risk are heard within any assessment, unless it is deemed not appropriate to do so due to risk, age or ability. However practitioners must remember that spoken word is not the only form of communication and other methods should always be considered.

Assessments should be multi-agency and based on quality conversations with other practitioners involved with the family, sharing information and concerns as appropriate.

Assessments should also consider the resilience of, and supportive factors within, a family. The following factors can support the resilience of children within families affected by these issues, and should be considered within assessments and planning for interventions:

- A positive relationship with a family member or parental figure
- Influence of another stable adult
- Positive social support networks and a social role
- Positive school experiences
- A sense that their own efforts can make a difference to their lives
- A child's own coping skills, such as an ability to understand and express their feelings
- A child's view of themselves as separate from the problems in their family and who doesn't think they are to blame
- Plans for the future and things to look forward to
- Opportunities to develop their self-esteem and coping resources prior to their parents' problems or in between times of difficulty.

The following characteristics of parents can also enhance resilience in the family:

- A confiding relationship with a supportive partner or others
- The absence of parental conflict
- Parental self-esteem
- Social life and routines
- Positive coping strategies and deliberate actions to minimise the impact of problems on their children
- Receiving treatment
- Openness and good communication
- An understanding of their child's needs and how to minimise harm.

It should not be assumed that the issues impacting on parenting capacity have to be eradicated in order to ensure safety for a child. Practitioners should retain the notion of good enough parenting.

Harm reduction and engaging with the specialist help, advice and treatment they require (and are most able to engage with) must be actively explored and promoted with parents. Resistance is part of the change process and is often to be expected. Whilst keeping the child's needs as the central focus, all professionals should be mindful of how their approach can impact on a parent's ability to engage with them, and bear in mind that a confrontational style can increase resistance to change.

Where appropriate it is useful to ask parents the following:

- Why do they want to address the issues impacting of their parenting capacity and how will they bring about this change?
- How important is it to make the change?
- What contributes to when things are going well, how do they feel when this happens and how can they build on the strengths?

Finally and most fundamentally practitioners when undertaking an assessment should consider **w*ould this be good enough for my family?***

Practitioners unused to undertaking assessments of children and young people can seek advice and support from their safeguarding lead or the Integrated Processes Team on 0113 2476830.

Responding to Concerns

In order to determine the most effective response to emerging concerns about a family or an individual within a family, the Leeds Early Help Approach (2014) supports professionals to hold multi-agency conversations to explore concerns and potential provision of support.

Initial concerns should be discussed with line managers and agency safeguarding leads, and then discussed with the appropriate agency that is able to work with you to support the identified need.

Children and Young People

Once the level of support required is identified, practitioners should initiate the support by contacting the appropriate agencies dependent on that level. The following points of contact will help you to identify appropriate agencies:

Universal (Family Information Service)	0800 7310640 (Freephone)
Targeted and Cluster (Integrated Processes Team)	0113 2476830
Specialist (Children's Services Duty and Advice Team)	0113 3760336 0113 2409536 (out of hours)

If a child is at risk of significant harm Children's Services Duty and Advice Team should be contacted as above.

If a child is in imminent danger the police should be contacted.

Adults

If a person is in need of additional support in relation to their social care needs, they can contact Adult Social Care: Tel: 0113 222 4401

If a person needs additional support in relation to their health needs, contact their GP, or relevant health services involved.

Adults at Risk of abuse or neglect concerns regarding an adult who is unable to protect themselves from abuse or neglect due to their health and social care needs should be discussed with Leeds Adult Social Care - 0113 2224401 (out of hours 0113 240 9536).

If an adult is in imminent danger the police should be contacted.

The possible abuse of an adult at risk can be discussed with the Safeguarding Adults Partnership Advice Line: 0113 224 3511 (office hours Mon-Fri).

Further support or advice could be sought by contacting the adults GP or city wide services such as:

Community Drug Treatment Service (0113 2421161)

ADS Leeds (0113 2470111)

Leeds Addiction Unit (0113 295 1300)

Leeds and York Partnership Foundation Trust (0113 3055952)

Leeds domestic violence 24 hour helpline (0113 2460401)

Women's Aid www.womensaid.org.uk

Anti-social behaviour contact centre (0113 2224402)

Stop Hate UK (0800 1381625)

Further support services can be found on the Leeds Adult Safeguarding Board website

Young Carers

Young carers can be defined as "children who look after someone in their family who has an illness, a disability (impairment), a mental health problem or a substance misuse problem. Young carers take on practical and/or emotional caring responsibilities that would normally be expected of an adult." (Princess Royal Trust for Carers, 2010).

Often in families where parenting capacity is reduced one or more children take on the role of a young carer. In such situations it must be recognised that they too may have needs which should be assessed and responded to, and this is being nationally recognised through the Children and Families Bill (2013); "Children and young people who care for family members are to benefit from a full assessment of their support needs so they receive help and assistance to experience the same opportunities as their friends".

Therefore, all practitioners who are aware of a young carer, because they are either working directly with the child or with the adult who is being cared for, should assess the needs of the child within that role and respond appropriately.

Action Planning

Once an assessment has been completed, actions should be developed, agreed, documented using your agencies processes and shared appropriately.

This guidance promotes multi-agency working in both undertaking the assessment and also determining how agencies will work together with the family to make progress on the actions agreed in order to improve outcomes for all concerned.

A Restorative Approach advocates that the family should be included in the whole process (unless this would place a child / vulnerable adult at greater risk). Actions should incorporate a restorative, solution focussed approach, 'restoring good' and building on strengths. Practitioners should support the development of capacity, resilience and independence of families by building on their strengths and enabling them to identify their own solutions and take responsibility for their future.

In order to ensure active multi-agency oversight is maintained on progress and to avoid 'drift' actions should be 'SMART' (Specific, Measurable, Agreed, Realistic and Timely) and be regularly reviewed. This will also ensure clarity of agency roles and responsibilities. Any plans should also be regularly reviewed and updated to reflect the changing assessment of the family and their needs as these are addressed.

Residential or hospital treatment

If a parent is undertaking residential or inpatient treatment professionals involved in planning for providing the treatment should be alert to the implications for the service user's child. If there is not another suitable parent or carer taking responsibility for the child's care, they may need to be cared for by other family members or placed in local authority care such as a foster placement.

If professionals become aware of families entering into private 'fostering arrangements' they should alert Childrens Social Work Services if the arrangement will last for 28 days or more, or if they have any concerns (or a lack of information) about the suitability of those arrangements.

Professionals should also consider along with the parent, child and relevant professionals the need to maintain contact between parents and their children during the treatment period, facilitating visits or other forms of contact in a way which is safe, suitable and in the child's best interests.

Hospital or residential staff should not assume parents know about sources of support in the community. Discharge planning should take account of services that might support the family after treatment, and the child's social worker (or lead professional from children's services if applicable), should be invited to meetings.

Aftercare

When professionals working with the parent are planning and reviewing after-care support, they should consider how to support the parenting role of the service user and be mindful and proactive in supporting the welfare of the child. This may involve making referrals for services such as parenting groups, family support/visits to the home, childcare provision or helping parents to identify and access suitable community, or support from friends and family.

Professionals working with adults should consult and work with professionals involved with the child as part of this. Everyone, including parents, should be alert to triggers and signs of potential relapse, and make plans together for preventing and responding to these.

Barriers to effective multi-agency working

Practitioners, regardless of their agency, must ensure they work together to ensure an appropriate assessment and response to the needs of all family members. Failure to examine the bigger picture and respond in a holistic way is often referred to as silo working and has been highlighted in numerous serious case reviews for example Child D, North Yorkshire SCB (2010).

Barriers to undertaking full assessments and responding appropriately include: fear; lack of knowledge or experience; workload; and disputes between agencies.

Practitioners should be clear of their own agency and individual **roles and responsibilities** with regards to their service users; however they should also be aware of their responsibilities to assess and support the needs of all members of the family they are working with, and respond appropriately, from signposting through to more direct provision of support.

Agencies should abide by their own **Information Sharing** Agreements whilst ensuring compliance with their statutory responsibility to share information where there are concerns that a child or young person is suffering or at risk of 'significant harm'.

The need for **consent** (and the consideration of capacity for Adults at Risk) should always been considered and discussed with Line Managers. By establishing consent to share information early on, practitioners can avoid some of the barriers that may arise later. Clarity of what information will be shared and with whom may provide reassurance and a greater likelihood of their agreement. This may be undertaken by a discussion and agreement, within Appendix C providing an example Information Sharing Agreement between agencies and individuals.

Information sharing guidance is produced by HM Government.

Professionals should be supported to appropriately **challenge** not just parents but also other organisations to ensure that the most appropriate plan is put in place to improve outcomes for children and young people.

Practitioners and their managers must give consideration to their own level of accountability for actions / omissions and address barriers through **supervision** and, where necessary, procedures for resolving professional disagreements.

Common Expectations

When working with a family, or an individual family member, whatever the issue impacting on parenting capacity, there are key things all workers should do. These are outlined below:

Expectation of adult services

1. Record names, dates of birth, GP and school of the children as well as who has parental responsibility. Any private fostering arrangements should be referred to the local authority. (Guidance on private fostering is available via the Leeds City Council website www.privatefostering.org.uk public)

2. Consider any adult at risk in the family and their decision making, mental capacity and risk of exploitation.

3. Consider the vulnerability of all children in the family but specifically under 5's and those with disabilities

4. Organisations providing adult services should equip their staff on engaging with, and talking to children and provision of information for them.

5. Ensure there is a safety / crisis plan which identifies someone the child / adult at risk can appropriately call for help

6. Practitioners should be aware of the need for respectful challenge of the parents and not accepting facts on face value.

7. Consider parental disengagement and hostility as potentially increased risk factors for the child. Have knowledge of the 'Working with uncooperative and hard to engage families' protocol (Leeds LSCB, 2013), along with the Sanctions (Assertive Engagement) Framework produced by Families First Leeds

8. Ensure the family make up and history is revisited at regular intervals and there is robust record keeping on this. Practitioners' should not assume that a parent / carer has no contact with their child purely on the basis that the child lives separately with an estranged partner. In such situations, practitioners' need to enquire about contact (supervised or unsupervised). Practitioners should also be aware that serious incidents have occurred when children in care have been rehabilitated back into the family or there has been a change in the male partner and services were not aware of the changes.

9. If an adult discloses historical abuse consider current risks to children (see Appendix D)

10. Consider the need for an Early Help Assessment if children services are not already involved in supporting the family.

11. If there are no identified concerns regarding children record this and continue to monitor.

12. Get consent to share information at as early a stage as possible and involve other agencies.

13. Attend and provide information to children service meetings as requested.

14. Send minutes of relevant support meetings to key children services practitioners.

15. Inform the child's social worker / lead professional of any significant deterioration in the parent's mental health, changes in treatment or treatment adherence, or if new information comes to light which has relevance to the adults overall progress and parenting capacity e.g. a return to substance misuse. This includes admission to hospital so that immediate care can be considered.

16. When planning and providing services and support to parents, consider the parent's childcare responsibilities and provide, or help them to access, suitable childcare provision to enable them to attend appointments, services and group treatments. Try to provide appointments at useful times, such as within school hours.

17. Recognise that where "vital family and other social roles and responsibilities cannot or will not be undertaken" an adult has critical care needs, under government guidance, and is eligible for support. (Carson, 2011) – consider need for alert to Adult Social Care where it is identified that an adult requires additional support (see P10).

Expectation of children services

1. Record names, dates of birth, GP and school of the children as well as who has parental responsibility. Any private fostering arrangements should be referred to the local authority. (Guidance on private fostering is available via the Leeds City Council website www.privatefostering.org.uk public)

2. Consider any adult at risk in the family and their decision making, mental capacity and risk of exploitation.

3. Consider the vulnerability of all children in the family but specifically under 5's and those with disabilities

4. Ensure there is a safety / crisis plan which identifies someone the child / adult at risk can appropriately call for help

5. Practitioners should be aware of the need for respectful challenge of the parents and not accepting facts on face value.

6. Consider parental disengagement and hostility as potentially increased risk factors for the child. Have knowledge of the 'Working with uncooperative and hard to engage families' protocol (Leeds LSCB, 2013), along with the Sanctions (Assertive Engagement) Framework produced by Families First Leeds

7. Ensure the family make up and history is revisited at regular intervals and there is robust record keeping on this.

8. If there are no identified concerns regarding parents record this and continue to monitor.

9. Get consent to share information at as early a stage as possible and involve other agencies.

10. Children's professionals should attend adult service meetings as requested.

11. Invite involved adult service professionals to statutory meetings held in respect of children, and consider inviting them to a non-statutory meeting if it might be helpful.

12. Send minutes of meetings to key adults' services and professionals.

13. Inform adult services of significant changes that will affect the parent or alter the needs of the child, for example if a child is returning home following a period of being in care.

14. Whether or not adult services are involved with a parent, utilise advice and information from those services in order to maximise your understanding of the parent's problems and the likely impact on the child.

Further Information and Support

Practitioners can gain further information and support through:

Leeds Safeguarding Children Board	www.leedslscb.org.uk
Leeds Adult Safeguarding Board	www.leedssafeguardingadults.org.uk
Safer Leeds	www.leeds.gov.uk/residents/Pages/Safer-Leeds.aspx

GUIDANCE IN RELATION TO PARENTAL MENTAL HEALTH

Definition

For the purposes of this guidance, the term 'mental health problems' includes parents who have, under the terms of the National Service Framework for Mental Health, common mental health problems like depression as well as more severe and enduring disorders such as schizophrenia, bipolar illness and personality disorder. However, it is recognised that responses from mental health services would differ based on the severity of parental problems and associated risks.

Common adult mental health conditions

The most common mental health conditions to affect adults in England are:

- mixed anxiety depressive disorder - a condition where a person experiences the symptoms of depression and anxiety; it is estimated to affect 1 in 10 adults in any given year,
- generalised anxiety disorder (GAD) – a condition where a person experience persistent and severe feelings of anxiety; is estimated to affect 1 in 20 adults each year,
- episodes of mild to moderate depression,
- phobias - an extreme, or irrational, fear, such as a fear of heights, or animals; phobias are estimated to affect 1 in 40 adults a year,
- obsessive compulsive disorder (OCD) – a condition where a person experiences obsessive thoughts and compulsive behaviours; is estimated to affect 1 in 75 adults a year, and
- panic disorders (also known as panic attacks) - which are estimated to affect 1 in 80 adults a year. (NHS Choices, 2013).

Complex adult mental health conditions

Complex adult mental health conditions are generally less common than the mental health conditions that are mentioned above, but they can have a greater impact on the quality of a person's life, day to day functioning and can be more challenging to treat. In addition, both safeguarding children and general risk issues (harm to self, harm to others, neglect, vulnerability etc) are more likely to develop.

Complex mental health conditions include:

- schizophrenia,
- bipolar disorder (also known as manic depression),
- severe depression or psychotic features,

- severe post natal depression / puerperal psychosis (these disorders can place both mother and baby at risk of serious harm and require management by perinatal psychiatric services),
- post-traumatic stress disorder,
- anorexia, and
- personality disorders

Personality disorders are a range of conditions that affect a person's thoughts, emotions, and behaviour. Secondary psychiatric services most frequently come into contact with those with antisocial and emotionally unstable types of personality disorder. A history of childhood adversity / trauma is not uncommon in these patients. Most people with personality disorders find it difficult to interact with other people and during crises there may be angry / aggressive outbursts, self destructive behaviour and evidence of maladaptive coping strategies e.g. self harm and/or substance misuse. (NHS Choices, 2013).

Other users of mental health services

Safeguarding children issues may also arise in individuals with a wide range of other disorders. These include:

- Developmental disorders e.g. autism / Asperger's,
- Dementia e.g. grandparents with significant cognitive impairment being left to look after grandchildren,
- Drug and alcohol dependency may also coexist with mental health conditions, and
- Organic brain disease e.g. stroke - many people who are recovering from a stroke experience symptoms of anxiety and depression. (NHS Choices, 2013).

Many parents are aware of the negative impact of their problems on their children and are fearful of losing custody of their children (RCPsych 2011). This can impact on the stigma of mental illness and underpin hidden harm to both parent and child as needs are not addressed. .

Impact on children

Parental mental ill health "can have an impact on the needs of a child in a variety of ways and is strongly associated with poor outcomes in children." (RCPsych 2011).

In addition to the impacts identified on P6, children and young people living with a parent in these circumstances are at greatest risk when:

- the child features within parental delusions or hallucinations (of particular concern is when the parent experiences auditory hallucinations i.e. hears a voice or voices telling them to harm a child);
- the parent talks about entering into suicide pact with the child;

- the child becomes the focus of the parent's anxiety or aggression (irritability is a common feature of conditions such as mania, acute psychosis and post natal depression); or
- a parent with significant mental health difficulties is a single parent with minimal family support and nobody to raise the alarm when they are in crisis or relapsing.

The National Patient Safety Agency Rapid Response Report states the following:

- A referral must be made to Children and Young People's Social Care if service users express delusional beliefs involving their child and/or if service users might harm their child as part of a suicide plan.
- A consultant psychiatrist should be directly involved in making a clinical decision for service users who may post a risk to children.

The LYPFT Named Doctor would also strongly recommend that a referral is made to Children and Young People's Social Care when the service user hear a voice or voices commanding them to harm a child.

In addition, practitioners need to be aware that in the case of an acutely mentally unwell parent, who is in sole charge of a child, who refuses to allow access to their property for assessment; the most appropriate intervention may be to seek the assistance of the Police to gain access to the property to safeguard the child rather than delay intervening whilst a mental health act assessment is being organised.

Expectation of adult services

In addition to the general guidance described within this document and that for all adult service practitioners on P14, practitioners should:

1. Ensure that care planning and discharge planning considers risk factors and the need for early help using a multiagency approach either via CPA (Care Programme Approach) or the Early Help Assessment

2. Send minutes of CPA meetings to key children' services practitioners.

3. Referrals to Children's Social work must be made:
    a. if service users express delusional beliefs involving their child,

       and/or

    b. if service users might harm their child as part of a suicide plan. (NPSA, 2009)

Expectation of children services

In addition to the general guidance described within this document and that for all children service practitioners on P15, practitioners should:

1. Check whether the adult is known to mental health services through the GP or the community mental health team (CMHT).

2. If known contact the named safeguarding professionals for the relevant organisation and request advice if they have concerns or make a referral, including a verbal discussion and written information as required, to the relevant CMHT duty team.

3. Routinely record whether a parent has a mental health problem and if the adult does not meet the threshold of the CMHT consider getting advice from their GP or other involved mental health service professionals, or utilise the knowledge and expertise of the CMHT for informal advice.

4. The mental health worker must be informed if a child is returning home following a period in care or accommodation, or if other major changes that may affect the parent are anticipated.

5. Invite mental health professionals to statutory meetings and core groups, and consider inviting them to non-statutory meetings if useful.

6. Children's professionals should attend CPA and other adult mental health service meetings as requested.

GUIDANCE IN RELATION TO PARENTAL SUBSTANCE/ ALCOHOL MISUSE

Definition

When referring to parental substance misuse, this protocol will apply to parents who misuse alcohol and those with 'problem drug use' defined by the Advisory Council on the misuse of drugs as having:

> *"…serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them."*

Impact on children

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Research suggests alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings. Parental substance misuse has been found to feature in 25% of serious case reviews. (Public Health England, HM Govt, 2013).

A third (66,193) of all adults in drug treatment have childcare responsibilities (NTA, 2012). For some, this encourages them to seek treatment, and being in treatment will be a significantly protective factor for the children. Data shows that parents, who enter treatment, engage and successfully complete at a similar level or better than other people in treatment. However, some of the children affected may be at risk of neglect, they may be taking on inappropriate caring roles and in some cases they may be experiencing serious harm. (Public Health England, HM Govt, 2013.)

The misuse of alcohol by parents negatively affects the lives and harms the wellbeing of more children than the misuse of illegal drugs. Yet too often, parental alcohol misuse is not taken as seriously, in spite of alcohol being addictive, easier to obtain, and legal. The effects of parents' alcohol misuse on children may be hidden for years, whilst children try both to cope with the impact on them, and manage the consequences for their families. (Silent Voices, 2012).

(Silent Voices, 2012)

In addition to the impacts identified on P6, children and young people living with a parent in these circumstances are at greatest risk when:

- Drug and alcohol use occur together or there is poly-drug use.
- There are chaotic lifestyles.
- There are babies, very young children or children with disabilities within the family unit.
- Mothers use substances during pregnancy which may result in foetal alcohol syndrome or neonatal abstinence syndrome in babies.

Expectations of adult services

In addition to the general guidance described within this document and that for all adult service practitioners on P14, practitioners should:

1. Consider the following; what is the substance? When is it used? How is it used? Where is it used? And then consider what is the impact on the user / child / adult at risk?

2. Consider increased risk if both partners are misusing substances/alcohol and if the other partner accesses a different service, ensure good liaison takes place and engagement is monitored.

3. Consider additional complexities which may increase risk or likelihood of repeat incidents such as domestic violence, and mental health issues.

4. Ensure robust multiagency discharge planning which ensures clarity of who will be involved with the family once the substance misuse team pull out (an Early Help Assessment will help to ensure this safety net is in place).

Expectations of children services

In addition to the general guidance described within this document and that for all children service practitioners on P15, practitioners should:

1. Routinely record whether a parent has misuse problems on the child's case records and for internal data collection purposes to aid service planning.

2. Explore with the parent the option of making a referral to an appropriate substance misuse service, informing them of the support potentially available locally and nationally.

The following flowcharts below indicate the considerations required for agencies when working with adults who misuse substances. An inclusive and restorative approach will encourage engagement and hopefully reduce secrecy and the negative impact associated.

GUIDANCE IN RELATION TO DOMESTIC VIOLENCE

Definition

Domestic violence is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and / or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."*

Men as well as women can be victims of domestic violence however women are more likely than men to be victim of multiple incidents of abuse, of different types of and is clear that victims are not confined domestic abuse (partner abuse, family abuse, sexual assault and stalking) and in particular of sexual violence, (Women's Aid, 2013).

Almost a third of domestic violence and abuse starts during pregnancy. If it starts before pregnancy, it can get worse over the nine months, (NHS choices, 2014).

What are the signs?

If an individual is forced to change their behaviour because they are frightened of their partner then they are being abused. If they are experiencing any of the following then it's likely that they are being abused:

- Is the partner jealous and possessive?
- Do they cut their partner off from family and friends and try to isolate them?
- Are they charming one minute and abusive the next? Do they have sudden changes of mood?
- Do they control – for example, their partner's money, who they should see, what they should wear?
- Do they monitor movements?
- Do they blame their partner for the abuse?

- Do they humiliate or insult in front of others?
- Do they verbally abuse their partner?
- Do they constantly criticise?
- Do they use anger and intimidation to frighten and get compliance with their demands?
- Do they tell their partner they're useless and couldn't cope without them?
- Have they threatened to hurt their partner or people close to them if they leave?
- Does the partner change their behaviour to avoid provoking anger?
- Do they force their partner to have sex when they don't want to?

There are many different ways of being abusive. For example:

- Damaging possessions
- Smashing up the furniture
- Threatening to harm or kill the pets
- Threatening to kidnap or get custody of the children if they leave
- Locking their partner out of the house during an argument
- Terrorising them by driving fast or through red lights at high speed because they knows it frightens them

Impact on children

In relationships where there is domestic violence, children witness about three-quarters of the abusive incidents. About half the children in such families have themselves been badly hit or beaten. Sexual and emotional abuse are also more likely to happen in these families. (RcPsych, 2013).

The emotional impact is great, behavioural and emotional problems, both internal (such as depression and anxiety) and external (such as aggression or anti-social behaviour) (Humphreys, 2006). However, the distress can also manifest in physical symptoms such as eating and sleeping problems, aches and pains, self harm and bedwetting. (RcPsych, 2013; Lamers et al, 2012).

In addition to the impacts identified on P6, children and young people living with a parent in these circumstances are at greatest risk when:

- Children are "used" by the perpetrator either as a go between, messenger or allies
- Children are very young / babies (including per-birth)
- At the point of exit – when the victim decides to leave the perpetrator and takes their children with them

Although the government definition defines domestic abuse as occurring amongst those of aged 16 or over, it is recognised that child to parent/ sibling/ family member abuse can also be a factor. Leeds Domestic Violence Services acknowledge this, and as such both 16+ young people as well as adults are discussed at MARAC's (Multiagency risk assessment conferences) for domestic violence. Commissioned services however, address violence perpetrated by young people through child protection plans as opposed to adult services. Under 16's are also addressed via child protection processes.

Expectations of adult services

In addition to the general guidance described within this document and that for all adult service practitioners on P14, practitioners should:

1. Be aware of the signs and indicators of domestic abuse and ask relevant questions where it is safe to do so.

2. Create an environment conducive to enabling disclosure e.g. by displaying posters, having appropriately trained and supervised staff.

3. Have knowledge of where to signpost the victim for help.

4. If a domestic abuse is reported to you record this considering the need for confidentiality (especially in relation to correspondence with the perpetrator). With consent, share this information with agencies involved. Be mindful of sharing information with the abusive parent / partner which may place the non-abusing adult / children at risk (especially if the parent and child have moved out of the family home).

5. If supporting the non-abusing parent and their children to exit the family home ensure all accommodation is appropriately assessed for housing children.

6. Be familiar with the DASH risk assessment form and MARAC process and link with your agency representative (see www.caada.org.uk)

Expectations of children's services

In addition to the general guidance described within this document and that for all children service practitioners on P15, practitioners should:

1. Routinely record known instances of domestic abuse on the child's case records considering need for confidentiality (especially in relation to correspondence with the perpetrator).

2. Be mindful of sharing information with the abusive parent / partner which may place the non-abusing adult / children at risk (especially if the child has moved out of the family home).

3. Explore with the non-abusing parent the option of making a referral to an appropriate domestic abuse service, informing them of the support potentially available locally and nationally.

4. Consider need for support for the child if the non-abusing parent exits the relationship (more so if moving into hostel accommodation) – work with both the parent and any support services.

5. Be familiar with the DASH risk assessment form and MARAC process and link with your agency representative (see www.caada.org.uk)

GUIDANCE IN RELATION TO PARENTAL LEARNING DISABILITIES

Definition

Learning disabilities are defined as

"A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development". (Department of Health, *Valuing People* 2001)

Impact on Children

From a survey of parents with learning disabilities, just over half (52%) looked after their children. Women were slightly more likely to be a parent than men (9% compared to 6%). But men and women were just as likely to be looking after their children if they had any (52% of women, 53% of men). (Emerson et al, 2004).

In 2010 Ofsted identified that "the disability of children or family members was usually considered only when the subject of the review was a disabled child. There was little consideration of the full impact when siblings were disabled or when parents had a learning disability or suffered from mental ill health. This was particularly the case for families where older children were young carers."

In addition to the impacts identified on P6, children and young people living with a parent in these circumstances are at greatest risk when:

- A parent's learning disability is not identified and / or level of support required assessed - many parents with learning disabilities face stereotyped beliefs that they could never be good enough parents, such that any parenting difficulties are automatically linked to their learning disability without considering other environmental or social factors.

- Parents do not access appropriate services such as antenatal care or child care support services – this is often due to of lack of confidence, negative staff attitudes, lack of clear explanations of what is going on, inaccessible leaflets, and fear of the involvement of social services.
- Increased social issues are present - parents with a learning disability are often affected by poverty, social isolation, stress, mental health problems, low literacy and communication difficulties

Valuing People: A New Strategy for the 21st Century (DH 2001 p81) states that "People with learning disabilities can be good enough parents and provide their children with a good start in life, but may require considerable help to do so." In addition Carson 2011 stated that "The issue should not be whether you are a great parent; it's about whether you are a good

enough parent". Ofsted (2011) report that this is a much about a secure attachment as much as the meeting of the child's basic physical needs.

Expectations of adult services

In addition to the general guidance described within this document and that for all adult service practitioners on P14, practitioners should:

1. Start from the position that people with learning disabilities can be good parents if they receive the right support and information.

2. Provide information in accessible formats from before birth, such as advice booklets produced by the charity Change. (www.changepeople.co.uk)

3. Adhere to and utilise joint protocols with children's services defining how you will work together to support learning disabled parents.

4. Parents are entitled to access independent advocacy and should be supported, where necessary, to access it

5. Be aware of the risk of sexual exploitation in children and adults at risk and be able to recognise the signs. Practitioners in learning disability fields should contribute to multiagency planning and citywide initiatives to support better addressing of CSE and adult exploitation.

Expectations of children services

In addition to the general guidance described within this document and that for all children service practitioners on P15, practitioners should:

1. Routinely record a parent's learning disability on the child's case records and any considerations required when working with the parent, for example a support worker.

2. Assessments involving families affected by parental learning disability should always include specialist input concerning the impact of learning disability

3. Where it is a partner (who may or may not have learning disabilities themselves) who poses a risk of harm to the child it will be important to support the other parent to protect the child.

4. Parents should be invited to attend meetings regarding their child and support should be provided to enable them to fully participate.

Appendix A

My World Assessment Triangle

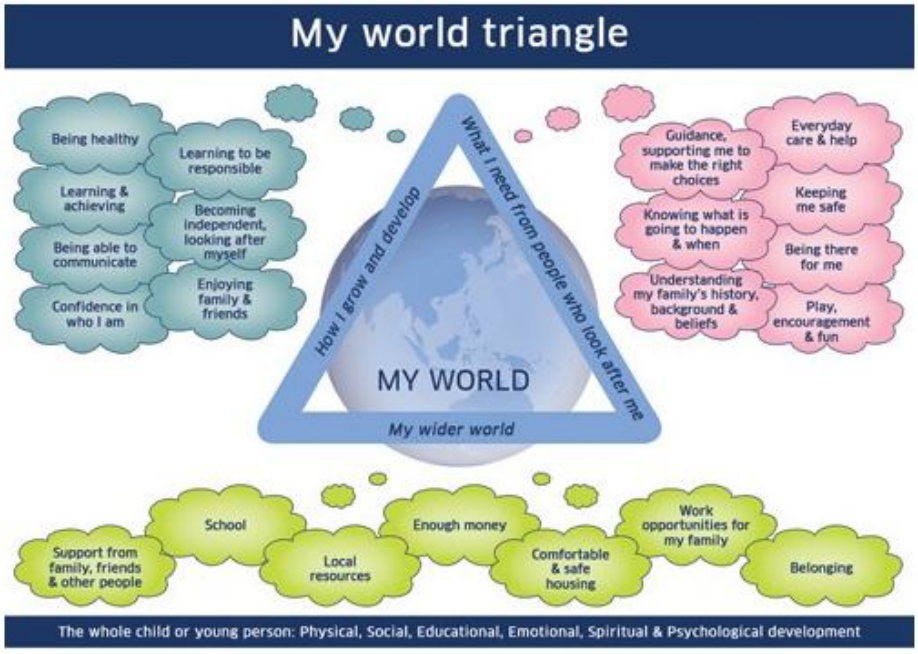
An alternative to the Assessment Triangle which can be used with children and young people when undertaking assessments. An online interactive version can also be accessed at www.nhconline.net/nhconline/triangle/

The *My World Triangle* supports practice that considers the child or young person's needs and risks, as well as the positive features in their lives. Strengths and pressures are given equal consideration and can be structured around the triangle. Information gathered should be proportionate and relevant to the issues in hand. In many cases, it will not be necessary to explore every area of the triangle in detail but only to look at those relevant to any presenting issue. However, it is still important to keep the child or young person's whole world in mind and provide immediate help where necessary while continuing assessment.

Using the *My World Triangle* allows practitioners to consider systematically:

- how the child or young person is growing and developing
- what the child or young person needs from the people who look after him or her
- the impact of the child or young person's wider world of family, friends and community

The child or young person should be involved in exploring the different facets of the triangle as part of a restorative approach.



www.scotland.gov.uk

Appendix B

Example Questions to support the Assessment Process

1. Who are the children?
   Document their name, age, date of birth, GP, school where applicable.
   Consider:
   - where the child lives, permanent address, temporary address e.g. with a separated partner
   - who else is involved with the child – midwife, health visitor, school, social worker etc.
   - who has parental responsibility - are there any private fostering arrangements which need to be reported to the local authority?

2. Who are the parents?
   Document name, age, date of birth, GP
   Consider:
   - are they together?
   - is there another partner who may pose a risk?
   - what are the protective factors?

3. Who is the adult at risk?
   Consider:
   - what are their difficulties?
   - who is involved?
   - do they have mental capacity?
   - This may be an extended family member living in the household who may be at risk.

4. What are the strengths?
   Consider:
   - factors promoting resilience e.g. protective factors, supportive family network, attachment to a caring adult, good school attendance, sense of self-esteem, sense of control

5. What are the issues in the family?
   Consider:
   - whether there is mental ill health, substance misuse, learning disability, domestic abuse, historic abuse?
   - what are the needs identified by the family / young person themselves?
   - inappropriate caring responsibilities, youth offending, CSE, disability, vulnerable under 5's, children missing education, pregnancy, children who are looked after and adult care leavers

6. How does this impact?

7. How good is engagement with services?
   Consider:
   - poor engagement can be a risk factor, is there hostility from the parents / service user
   - is there disguised compliance i.e. is the adult saying 'the right things' to assuage the practitioner or is there evidence of actual improvement

8. What opportunities are there to ascertain the views of the child / adult at risk?
   Consider:
   - where a child is old enough or sufficiently mature, staff, whether working with the child or the parent should create opportunities to get the views of the child around their current wellbeing and any concerns.
   - details of a practitioner they can contact if they have questions or concerns about themselves or their parent, should be given.
   - if there are language barriers, interpreting should be undertaken by an independent interpreter, not a family member.
   - with an adult at risk, their mental capacity should be assessed and access to interpreters or advocacy services provided, if required.

9. What are the risks? What are the needs?
   Consider:
   - routine enquiry into whether there is historic or current domestic violence if appropriate.

10. Who do I need to speak to gather more information?
    Consider:
    - what other agencies are involved with the family and what conversations might be needed e.g. is the other partner accessing a different drug / mental health service?
    - do I need to check if child / adult social work are involved / hold any historic information?
    - has a CAF / Early Help Assessment been initiated?
    - does the GP / Health Visitor / children's centre / School Nurse know or need to know anything?

Appendix C

Example Consent Form (based on that used by Families First Leeds)

We want to make sure the support provided is being delivered in a way that best suits your family's needs, and to enable us to do this we need your participation in this process.

To ensure you receive the best quality of care and support, we will need to share your information with other services who may be involved with your family. This is known as a multi-agency approach and your agreement for us to share information is an essential part of the process.

It is important that you sign this form to provide consent on the understanding you have had the following fully explained to you:

- I have had the reasons for information sharing explained to me and I understand those reasons;
- I understand that the support I will receive is consent based which requires me to agree to the plan of work and not consenting could affect the services I receive;
- I understand that the information I share will be stored securely and used for the purpose of providing services to me and my family;
- I have had the opportunity to ask questions about how my information will be used;
- I consent to (name of organisation) contacting other agencies who may have knowledge of my family so they can carry out an assessment and build a team around my family;
- I agree to work with the 'Team around the Family' and for the information I provide to be shared with the agencies involved in supporting me;
- I consent to health information regarding me / my family being shared;
- I understand that the safety and welfare of children and adults at risk is paramount and that, if there is any concern regarding the safety and welfare of a child or member of the public, professionals can share information without my consent;
- I understand that a support plan will be developed in partnership with my family, and I will be asked to agree actions within it to achieve positive changes. I understand that if I do not keep to agreed actions further action may be taken;
- I have been given the opportunity to identify and discuss the services I do not agree to share all or some information with - these are listed below:

Service	Limits of Information to be shared

I understand that the information shared by all services and agencies will be about myself and my family (named below):

To be signed by all adult household members

Print Name	Signature	D.OB	Parental status

Checklist for Lead Practitioner / Key Worker

Complete as appropriate:

Information shared with Family:	Y/N	Comments
Confidentiality Discussed		
Consent to work outside of family home if necessary		
Family agreement explained		
Review process		
Relevant contact numbers		
Information sharing		

Competency to Consent	Y/N	Comments and evidence
Is the individuals understanding of their situation compromised in any way e.g. learning difficulties, intoxication mental illness/health		
Is the individual capable of understanding information given to them e.g. can they demonstrate this or is a review required		

Lead Family Practitioner:

Name ……..... Signature ..... Date .....

Line Manager:

Name ……..... Signature ..... Date .....