Think Family:

Valuing Parents and Improving Safeguarding for Children and Young People

Leeds joint working protocol for parents with substance misuse, mental health or dual diagnosis problem, to improve outcomes for children and young people living in these families.

Leeds Safeguarding Children Board

Acknowledgements

The Parenting Fund financed the initial research which led to the development of this protocol in partnership with Leeds City Council and the National Children's Bureau. The National Children's Bureau conducted the initial research, drafted and consulted with services as this protocol developed.

There are too many members of staff from adult and children's services to list each one individually that have contributed in some way to get Leeds City Council and its partners to this point on the journey. We need to work in a new way with families where parental substance misuse or mental health or dual diagnosis is an issue that influences children and young people's outcomes. Lots of individual service users have contributed significantly to this protocol.

However, the following areas have contributed significantly to this protocol constitently over the entire development stages:

Leeds City Council - Early Years Service
Integrated Processes Team
Director of Children's Services Unit
Children and Young People's Social Care
Adult Social Care

Leeds Community Safety and their commissioned services

Leeds Partnership Foundation NHS Trust - Leeds Addiction Unit
Safeguarding Team
Perinatal Mental Health Service
Community Mental Health Service

Leeds NHS Community Healthcare

Leeds Teaching Hospitals NHS Trust

Thank you also to those who have developed protocols in local authorities and organisations which have been made available to others and which we have drawn on and referenced within this protocol. In particular; Greenwich, SCIE, Tower Hamlets, Camden and Islington, Claire Cairns, Central and North West London Mental Health NHS trusts.

Forward

This protocol aims to improve the safeguarding and broader outcomes for children and young people living in families with a parent or parents who misuse alcohol or other substances, or have mental health issues or a combination of these.

Parents who are coping with substance misuse and/or mental health issues care about their children and want the best for them. This protocol resulted from evidence-based research that demonstrates that children and young people can be better safeguarded and their outcomes improved by adults' and children's services working together around the needs of the whole family.

For too long, professionals have tended to work in isolation of each other and of services working with the family. At times, we are unaware of who lives within the family and which other agencies may be contributing towards the family's wellbeing.

By working together and putting the family at the centre of shared work, we can reduce the risks to all members of the family, whilst empowering them to make choices and take control of their lives individually and as a family.

We would like to thank the many individuals and organisations who have contributed to this work to develop a protocol that will take services for families forward. The Parenting Fund enabled the initial research to get underway and, in the course of this work, many staff from both adults' and children's services made valuable contributions. A number of local authorities generously made available their own protocols and published materials, which we have fortunately been able to draw upon.

Families in Leeds have a right to have the best quality services and protection we can provide. This Protocol is a further step along the way to making this aspiration a reality.

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Introduction

Most families have a range of needs and from time to time will require support or services to help meet them. Difficulties that impact on one family member will inevitably have a knock-on effect on other family members. For example, if a parent has mental health problems or problem drug or alcohol misuse, it is likely to have an impact on their children or other family members. Or if a child has a severe learning disability or complex health problems, this will impact greatly on their parent or siblings.

When families are affected by additional problems such as those mentioned, their need for effective and co-ordinated support is greater. Families need services that understand their wider needs, including the importance of their relationships and roles within their family, and that are able to provide support and advice at an earlier stage as possible before their problems become worse.

However, it is often in these circumstances that families will be faced with having to deal with a number of services which are set up to work with single issues and individual family members. If these services fail to work together in a way that complements what each is trying to do, then they may increase the stress and difficulties experienced by the family.

Research and literature about families' needs and service responses has repeatedly shown that all too often services are not working together effectively enough and often do not become involved with families until their situation has reached crisis point. Failures to provide support early enough and to take a 'whole family approach' can result in children's safety being compromised and families breaking up. The government recognised this and has set an agenda to develop better support to families with complex needs as described in the Social Exclusion Unit Report - *Think Family: Improving the Life Chances of Families at Risk*

"*in a system that ' thinks family ' contact with any service offers an open door into a broader system of joined up support. This does not mean that every problem is solved by every service, but that staff see any moment of engagement as an opportunity to identify need and direct support to the individual and their wider family. Front-line staff are alert to wider individual and family risk factors, and practitioners consider the causes and wider impacts of presenting problems.*" (Think Family: Improving the Life Chances of Families at Risk, Social Exclusion Task Force, 2008) http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk/

All services in Leeds do need to work differently – i.e. – meet all the needs of all people, and for this reason have developed the joint working arrangements contained within this protocol.

Scope

This protocol sets out the agreed expectations and responsibilities of children's and adults' services when working with individuals or whole families who are likely to require the support of more than one service; for example, when affected by parental mental health problems or parental substance misuse. The aims, values, principles and practice guidelines apply to all professionals, including those in health, education, social care and voluntary agencies.

Protocol objectives

- To promote children's safety and wellbeing by supporting families wherever possible
- To clarify what people can expect from services that are involved with them
- To ensure services co-ordinate their work with family members when assessing their needs and when planning and providing services to them
- To encourage professionals to make better use of each other's expertise
- To ensure that all services take account of the wide range of people's needs
- To ensure that important information about children and families is collected and shared appropriately in order to benefit them
- To establish a shared language and some common aims and values between adults' and children's services

Values and principles

- The welfare of children is more important than anything else
- Professionals working with individuals must consider the impact of their work and the individual's circumstances on other family members
- Family members needs and views must be a central consideration when decisions are made that affect them
- Children affected by parental problems may have less opportunity than others, and all services should promote children's chances of fulfilling their potential
- Support should be provided to people as early as possible when it can have the most impact
- When eligibility criteria for a service are not met, professionals still have a role in making referrals, sharing information and consulting with others
- When both children's and adults' services are working with family members, they must draw on each other's knowledge and expertise and co-ordinate their work

- Professionals should be aware of how their approach can either support or undermine the trust of family members and strive to work in partnership

- Professionals must receive the training they need to give them the knowledge and skills to keep children safe and support families effectively

Legal and policy context

The law requires a range of children's and adults' services to co-operate to protect and safeguard children. Some services do have the lead roles and obligations under current legislation in respect of matters such as child protection assessments and investigations; for example children's social care services. Nonetheless, other agencies such as education and health also have explicit legal duties to co-operate in protecting children from harm and neglect.

The legislation and policy relevant to service provision for families affected by parental mental health, substance misuse and child welfare issues are as complex as the issues with which they deal, with a raft of legal and policy measures which have been introduced at different times and for different reasons. The consequence of this can be a lack of clarity and a failure by legislators and service planners to make links between different services and areas of policy and practice. Below is just a summary of key legislation and guidance in relation to child protection and safeguarding services.

Children Act 1989

The core principle of the Act is that the welfare of the child should be the paramount consideration whenever agencies are working with children and young people and/or their families.

In the Act, children in need are defined as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services (s17(10) of the Children Act 1989). This definition also includes children who are disabled.

The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are what would happen to a child's health or development without additional services, and the likely impact the services will have on the child's standard of health and development.

Section 17 of the Act includes a requirement for services to provide family support services for children in need, and the *Framework for the Assessment of Children in Need and their Families* (DH 2000), Section 1.29 reiterates this.

The law lays a duty on local authorities to carry out investigations and make assessments where there is a danger of a child suffering, or being likely to suffer, 'significant harm' (Section 47 *Local Authority's Duty to Investigate*). The concept of 'significant harm' is the threshold that justifies compulsory intervention in family life in the best interests of children and young people:

- 'Harm' in this context means ill-treatment or the impairment of health or development including impairment suffered from seeing or hearing the ill treatment of another

- Whether the harm suffered by a child is 'significant' is determined by comparison of the child's health and development with that which could reasonably be expected of a similar child

- There is no absolute criteria in judging what constitutes significant harm – it may be the result of a single, traumatic event, or more often, of an accumulation of events, both acute and long standing

Every Child Matters (ECM)

All children to have the opportunity to achieve the best they can, measured against five outcomes - being healthy; staying safe; enjoying and achieving; making a contribution to society; achieving economic wellbeing. Services provided for children and young people should be supporting them to achieve one or more of these outcomes. Children at risk of underachieving should be identified and assessed, and should receive necessary services as early as possible.

For further information go to: http://www.dcsf.gov.uk/everychildmatters/

Children Act 2004

This Act provides the legislative framework for many of the ECM provisions. Section 10 introduces a reciprocal duty among a list of partners to promote co-operation to improve the wellbeing of children, with wellbeing aligned to the five outcomes for children. Children's Trusts partners were placed under a general duty to safeguard and promote the welfare of children. This Children's Trust approach to partnership working includes local authority education and social services (called children's services authorities), health, police, probation, youth offending teams, learning and skills councils and other agencies that work with children outside the statutory sector. In 2006 Local Safeguarding Children Boards replaced the non-statutory Area Child Protection Committees under the Act.

Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children. In his report into the death of Victoria Climbié, Lord Laming concluded that "the suffering and death of Victoria was a gross failure of the system."

One of the key reasons why the system failed Victoria so badly, and why it has failed other children over the years, is because key people and bodies which come into contact with children on a regular basis often fail to give sufficient priority to safeguarding and promoting the welfare of children.

Section 11 of the Children Act 2004 therefore places a duty on key persons and bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

Guidance on the Statutory Chief Officer Post of the Director of Adult Social Services and the best practice guidance on the role of the Director of Adult Social Services (Department of Health, 2006)

http://www.dh.gov.uk/Consultations/ResponsesToConsultations/ResponsesToConsultationsDocumentSummary/fs/en?CONTENT_ID=4134606&chk=YgE1iV

Best practice guidance recommends establishing clear protocols and procedures for joint working between adult and children's services.

Working Together to Safeguard Children : a guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2010).

Paragraph 2.28 outlines requirements for adult services to work within relevant child protection procedures and safeguarding arrangements; and paragraphs 2.102 to 2.105 state that adult mental health services have a responsibility to consider the parenting role, and needs arising from this, of their clients.

Practice guidelines

What is abuse and neglect?

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger; for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child.
Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing the child to frequently feel frightened or in danger, or the exploitation or corruption of a child. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs (Working Together to Safeguard Children 2010).

Immediate risk

All services need to be alert to the possibility of significant harm to children and to signs of abuse and neglect. Significant harm can occur as a result of immediate risks or the cumulative impact over time of child's needs not being fully met.

Where any professionals have reason to believe a child may be experiencing, or are at risk of, significant harm, a child protection referral should be made to Children and Young People's Social Care on 0113 222 4403 (or the police should be called if there is an imminent danger) without delay and followed up in writing on the 'Request for Service or Referral Form' within 48 hours.

If both adults' and children's agencies are involved with family members already there must be urgent consultation and planning between them. For example, if mental health services are involved with a parent whose child is subject to urgent safeguarding intervention, Children and Young People's Social Care would need to consult with them so that the needs of both children and adults are addressed. A joint assessment of the situation should take place and a joint visit should be considered.

If the judgement is that there is a risk of significant impairment, as opposed to a risk of significant harm, then practitioners will need to find out if a Common Assessment (CAF) has been undertaken and if a Multi-Agency Plan with a named lead professional is already in place.

If a common assessment is in place practitioners should contact the lead professional and explain their concerns. These concerns will become a part of the CAF process and staff may be asked to support the multi-agency team around the child in delivering the plan that will support the needs of, and improve outcomes for, the child and family.

If a common assessment is not in place practitioners should contact the Common Assessment team to identify their concerns. They will name an Integrated Processes Co-ordinator (IPC) who will advise practitioners on the next steps. Staff may be asked to support the initiation of a CAF or initiate a CAF if they have undertaken CAF training. Practitioners can contact the Common Assessment team on 0113 247 6830 or can find out more about CAF training on the website: www.childrenleeds.org.uk

For further information on the Leeds Safeguarding procedures please go to:

http://www.leedslscb.org.uk/# or:
http://www.citycentreleeds.com/children/page.aspx?id=18113

Data collection and information sharing

Information gathered about the circumstances of service users, or their children/family members, should routinely be recorded on the case records. This information should also be recorded for internal use, such as service planning, and external use, such as performance monitoring by commissioners. The information will also provide baseline information to be passed on when making referrals to other services and to aid with joint assessment across services. This protocol must be used in conjunction with, and adherence to, the Pan Leeds Information Sharing Protocols:

http://www.procedures.leedslscb.org.uk/pdfs/Leeds%20Info%20Sharing%20Protocol.pdf

Adults' services

This section is adapted from the process outlined in Cairns, C (2007) Safeguarding the Children of Substance Misusing Parents.

All professionals working in adults' services should routinely ask service users whether or not they have children including other people's children who may be living with them. This information should be requested at the earliest possible point of contact, ideally at the initial assessment/triage stage and through cross-agency checks. The minimum information that should be gathered when there are children in the care of adult service users is listed in figure 1 below.

Figure 1 – minimum information requirement

- Name of child/ren
- Age of child/ren (ideally date of birth)
- Residency of child/ren (with client/ partner/ grandparents/foster carer) and address
- Main carer for child
- Current strengths and concerns expressed about the child (from client or anyone else)
- Current or previous involvement of other agencies, including social work
- Any assessments or plans the child has or had, including child protection plan
- Other services that are involved with the child/family.

Adapted from Cairns, C (2007)

If it is established that there is current social work involvement with Children and Young People's Social Care, or that there has been in the past year, details of the adult service's involvement should be passed on to the relevant team for their information.

If there is no current or recent social work involvement in Children and Young People's Social Care, and there has been no emergency or cause for concern leading to a child protection or children in need referral, adult workers should complete the CAF pre-assessment checklist (figure 2 below) using any information that has become available to them (provide link to CAF guidance and Pre-assessment Form) to identify if there are any potential needs in relation to the child.

Figure 2 - pre-assessment checklist

Does the unborn baby, infant, child or young person appear to be:
- Healthy;
- safe from harm;
- learning and developing;
- having a positive impact on others; and
- free from the negative impact of poverty?

If the CAF pre-assessment checklist identifies 'additional needs' for the child in any of these areas, the worker should establish whether a CAF has been done by contacting the CAF team on: 0113 247 6830 or the local e-CAF system. If a CAF has already been done, links should be made with the lead

professional so that they can consult with the adult's worker if needed. If not, the worker should discuss with the parent which, if any, professionals who are currently involved with them they would prefer to undertake the CAF. The worker should then discuss this with that professional and the CAF team so that an assessment can be co-ordinated and a package of support can be achieved for the child and the parent.

http://www.citycentreleeds.com/children/page.aspx?id=4304

Children's services

Children's services workers should be alert to adults' problems which may be affecting children. They should routinely explore whether parents or other key family members are affected by the following issues:

- Problem alcohol use
- Substance misuse
- Mental health problems
- Learning disability
- Homelessness
- Physical disability
- Domestic violence

As well as recording the presence of these issues on the case records and as a dataset to inform the service about prevalence, the identification or suspicion of the above issues must inform service responses.

When one or more of these issues are present, workers should, in addition to all other routine cross checks, establish which, if any, adults' services are involved with members of the family regarding these issues and inform them of their own involvement with the family.

After referral

Once a referral is made between adults' and children's services, the referring agency should follow up by consulting at an agreed time with the service referred to, in order to establish the outcome of the referral, progress made and any additional needs within the family that have arisen. If one service is planning to close the case they should build in time to ensure an appropriate handover.

Joint working

This section is from Camden and Islington Mental Health and Social Care Trust and Children and Families Department's *Joint Mental Health on Child Care Protocol* (2005)

In situations where both children's and adults' services have ongoing involvement with members of the same family/household or are carrying out a joint assessment, representatives from each service must be invited to any planning meetings or reviews held by each service.

Throughout the assessment process, there must be:

- sharing of information with the parents or carers, unless this would put the child in more danger or compromise a child protection investigation;
- clear communication between the services;
- sharing of individual assessments or relevant information;

- joint planning for ongoing work and provision of services that is recorded in the case records of the service; and
- a clear indication, reported on the case records, as to how, when and by whom the plan will be reviewed.

No major decisions should be made without the consultation of other key agencies unless urgency requires it and if to do so would cause unhelpful delay, in which case they should be informed as soon as possible.

Where appropriate and practical it is advisable to arrange a joint home visit from time to time. Otherwise, agencies should co-ordinate visits to ensure families are seen regularly.

In some circumstances it might be appropriate (and can be jointly agreed and recorded on case records) for one service to provide intervention, and for the other agency to provide consultation. For example, it may be that professionals form the view that the timing and the current mental health of a parent means they are more likely to engage with the professional they are most comfortable with, provided this does not increase risk to the child and that it's in the child's best interest to proceed in this way.

Informal consultation

In order to maximise the support available to families and to utilise the skills and knowledge of colleagues, there should be mechanisms for informal consultation and advice across services. This should be available even where cases do not meet eligibility criteria and aren't allocated within a service, but where a service has professional knowledge and expertise that can assist the service seeking support.

Case closure

If any service plans to close a case, the other key services must be informed, with at least two weeks notice, (four weeks if they have just referred the case on to the other service) in writing as soon as the decision has been made. They should outline the reasons for case closure and inform the other services of any discharge plan, aftercare support and alternative support systems that will be in place.

Finance

This section is taken from *Working Together to Support Disabled Parents – Adults Services Resource Guide 9, SCIE 2007*.

The financial implications of providing services should not be a barrier to providing support to families in a timely way. Decisions about resources must not delay or prejudice decisions about meeting families' needs. Arrangements should be in place to ensure this as follows;

- Financial responsibility is held by adult services where an adult has been assessed as eligible due to their individual needs, including supporting their parenting role.
- Financial responsibility is held by Children and Young People's Social Care or other children's services (as per service agreement) where children are assessed as being 'in need' or where there are safeguarding concerns.
- Where parents and children are both assessed as having eligible needs, financial responsibility is shared.

Disputes

Where service users or their families or staff feel they would like to challenge actions that have arisen as a result of this protocol, they should contact the Director of Children's Services Unit:

Director of Children's Services Unit
6th Floor East
Merrion House
Merrion Centre
Leeds
LS2 8DT

Supervision and training

Professionals should identify (in supervision or peer supervision if applicable) those on their caseloads who are part of a family affected by the issues addressed in this protocol, and regularly review the needs of children and/or potential impact on them of their parents' problems. They should regularly consider the need to joint work with other agencies to ensure co-ordination of services and support. Decisions and plans in respect of these issues should be clearly recorded.

Managers allocating and supervising cases where any of the parental problems covered in this protocol are present should ensure those they manage are aware of this protocol and understand what is required of them. Managers should provide support to all staff relevant to their level of knowledge and experience, and the opportunity to critically reflect on their work and its impact on children and families.

Managers and practitioners should also review their own learning and support needs, and take steps to address them to maximise their ability to undertake and support effective joint working.

Working with families with complex needs requires significant knowledge and skills.
This protocol shall be incorporated into all relevant training, at single-agency and multi-agency levels.

Joint working in specific circumstances

Parental substance misuse

Introduction

Definition and scope

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

Whilst parental substance misuse does 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 are in treatment and/or are stable in their substance use, have good support networks and are able to meet their children's needs. Some are aware of the potential effect of their substance use on their children and actively minimise it.
However when this is not the case, the impact of parental substance misuse on children can be serious and long lasting.

Children affected by parental substance misuse are at greatest risk when:

- substance misuse is coupled with mental health problems;
- domestic violence is occurring;
- drug and alcohol use occur together or there is poly-drug use and/or chaotic lifestyles; or
- they are babies, very young children or children with disabilities.

When parental substance misuse does have an adverse impact on children, the consequences can be very serious and 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;
- foetal alcohol syndrome or neonatal abstinence syndrome in babies;
- emotional, behavioural and social problems for children and young people; and
- severe neglect or abuse.

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.

The previous two lists are adapted from Sawyer, E, *Building Resilience in Families under Stress: supporting families affected by parental substance misuse and/or mental health problems* (2009).

When assessing the impact of parental substance misuse 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, when their parent is using substances and when they aren't?
- What are the strengths and protective factors?
- Is the parent's substance use 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 substance use likely to be within a timescale that will meet the child's needs?
- Have all agencies, including substance misuse workers, contributed to the assessment?

The above list was taken from Greenwich Council's *Protocols Agencies Working with Substance Using Parents and their Children* 2007.

It should not be assumed that parents have to be substance free. 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. This may be more realistic, complementing the approach of substance misuse services. 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, including those whose primary role is to address risks to children, 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.

It is useful to ask parents the following:

- Why do they want to change their substance use 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?

The focus of intervention should not be solely to change the parent's substance using behaviour at the exclusion of other family issues. For example, there may be a need to focus support around family disharmony, family violence, parental conflict, parental separation and loss or inconsistent and ambivalent parenting.

Research has shown a tendency for professionals to intervene less and/or later with regard to parental alcohol misuse than to parental drug misuse. However, the former should be taken as seriously, with consideration of immediate risks to children or the detrimental impact of their experience over time.

Substance misuse of all kinds can result in subjective and varied responses among individual professionals. It is essential for professionals to be mindful of their own value base and to guard against 'over-optimism' or negative assumptions. Most importantly of all, the child's experience and needs must remain the central focus.

Adults present in services with dual diagnosis, in the context of this protocol substance misuse/alcohol issues and mental health issues

A vast majority of these parents will fall into primary care mental health services. In Leeds, there is a city wide network which can provide information and advice for practitioners:http://dual-diagnosis.org.uk/

Procedures for joint working with parental substance misuse

When both adult substance misuse services and children's services are working with members of the same family, in addition to following the practice guidelines on pages 9-14 of this protocol, it is vital to do the following:

Expectations of adult substance misuse services

- If a service user is a parent and their degree of substance misuse and personal circumstances indicate that their parenting capacity is likely to be seriously impaired, a referral should be made to Children and Young People's Social Care services.

- When requested, substance misuse services should provide information to Children and Young People's Social Care (or a lead professional from children's services) regarding the nature of the parent's substance misuse and treatment services being accessed.

- Discuss with service users inviting the child's social worker (or lead professional from children's services) to meetings. If the parent does not agree to this, discuss with them their objections and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the children's social worker or another relevant children's professional such as health visitor, to attend part of the meeting. Minutes of meetings must be sent to all key professionals involved.

- Attend Children and Young People's Social Care statutory meetings when invited and provide information for meetings when requested.

- Provide informal information and advice to children's services staff even when the family being discussed is not allocated within the substance misuse service.

- Utilise the knowledge and expertise of children's services professionals in order to assess the potential impact of the service user's substance misuse on their children, to assist holistic work with them and to help decide if a referral for a CAF or to Children and Young People's Social Care services is necessary.

- 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.

Expectations of children's services

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

- 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.

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

- Send minutes of meetings to involved adult substance misuse professionals.

- Attend meetings when invited to by adult substance misuse services.

- Inform adult substance misuse 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.

- Whether or not adult substance misuse 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.

Residential or hospital treatment

If a parent is undertaking detoxification and/or residential rehabilitation 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' and they have any concerns (or a lack of information) about the suitability of those arrangements, they should alert Children and Young People's Social Care or the children's services lead professional so that they can do a welfare check.

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.

Pregnancy

Babies born to substance misusing mothers may experience withdrawal symptoms or 'neonatal abstinence syndrome'. As a result of this they need extended hospitalisation after birth and have higher needs at birth and into their early childhood.

While pregnancy may be a catalyst for change and is a strong motivator for mothers wishing to reduce or cease substance misuse, it is extremely important that they receive appropriate medical oversight when attempting to detoxify or reduce substance use within pregnancy. The objective is to achieve stabilisation at the lowest possible dose.

External factors (as well as medical) will influence the stability of the woman's health and substance use, so a holistic focus is needed with monitoring and reviews of changing needs.

Women in these circumstances may present late to maternity services due to chaotic lifestyles or a fear of being identified as misusing substances in pregnancy. This will increase the risks to the unborn child.

Pregnant women should be fast-tracked into treatment so that they can get appropriate medical support for them and their unborn baby as early as possible.

Engaging the partners of pregnant women, especially if they are also misusing substances, is likely to improve outcomes for pregnant women and their babies.

It is essential that obstetric departments, midwives, health visitors, community drug and alcohol services, GP's and prescribing doctors, paediatricians and Children and Young People's Social Care services, other key children's services and specialist provision such as the Leeds Addiction Unit (LAU), develop and maintain effective links with each other to enable a co-ordinated and complementary approach.

Planning for pregnancy, labour and postnatal support should draw on this wide network of professionals; assessing risk, identifying needs, setting goals and planning for support to be provided or accessed where already available.

The LAU is a specialist multi-disciplinary service which specifically works with pregnant substance misusing women and their partners. Anyone can refer women to them. Each case is looked after by a small team, including an addiction therapist, midwife, health visitor and, if necessary, a doctor. They review their service user's needs regularly and may refer them to Children's and Young People's Social Care at anytime. For example, if the service user has had previous children requiring social care intervention, if there is a loss of contact or if they have concerns about domestic violence or other child protection issues. They also formally review progress in a multi-disciplinary meeting 32 weeks into the pregnancy. See the flow chart on page 24 to view the process of joint work required for pregnant substance misusing women.

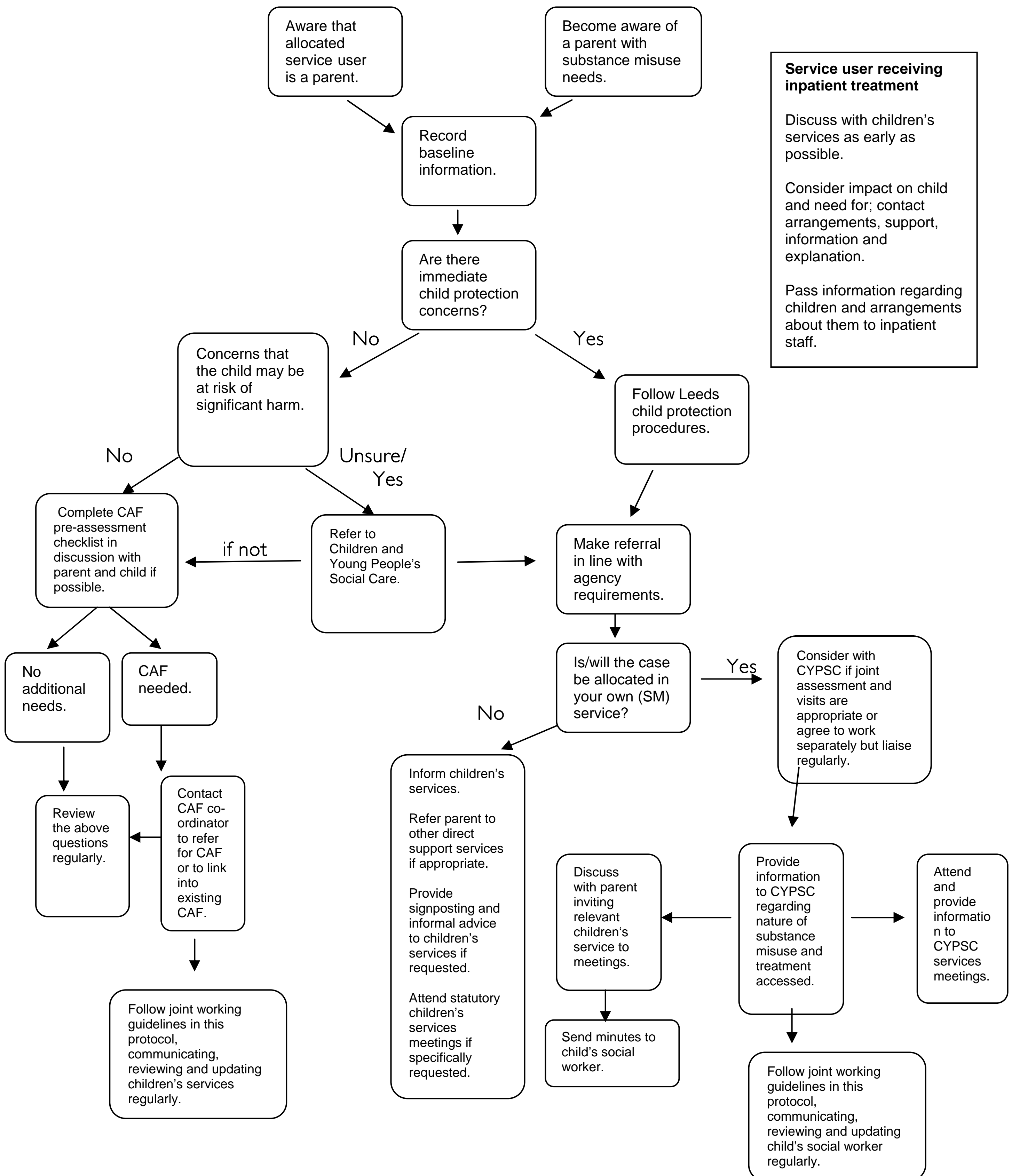
Young carers

A young carer is a child or young person who looks after a member of their family. Looking after a person might mean:

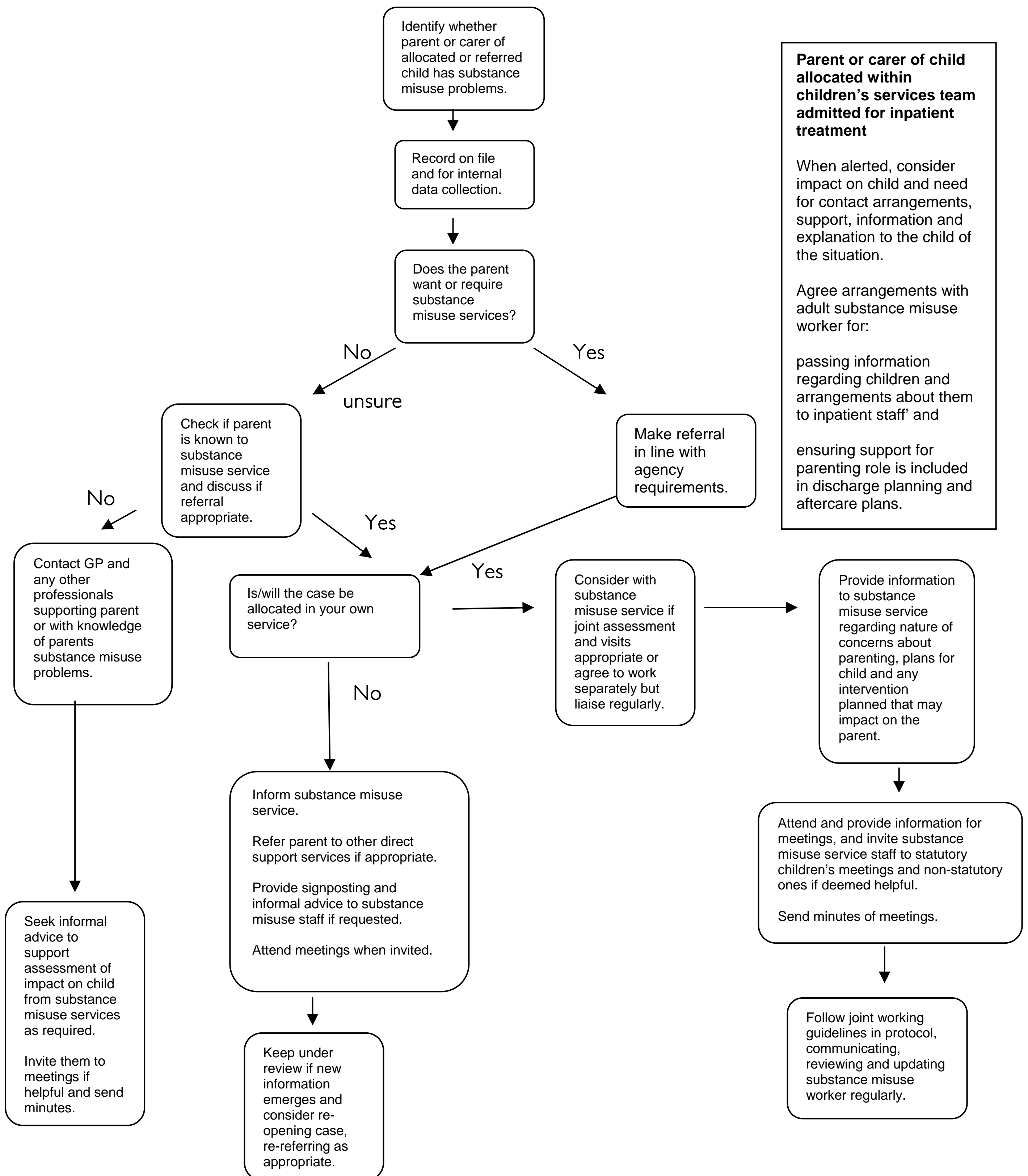
- listening to them and keeping them company;
- cooking meals and making drinks;
- visiting them in hospital;
- looking after brothers and sisters;
- providing personal care;
- doing shopping;
- helping with medication;
- cleaning and tidying the house;
- managing household finances; and
- providing other aspects of emotional or practical care and support.

Those working in adult services who work with parents need to take into consideration young carers in the home and the influence their actions may have upon them. For more information or advice contact Willow Young Carers Service: http://www.barnardos.org.uk/willow.htm

Protocol for adult substance misuse services working with parents



Protocol for children's services working with parents with substance misuse problems



Parent or carer of child allocated within children's services team admitted for inpatient treatment

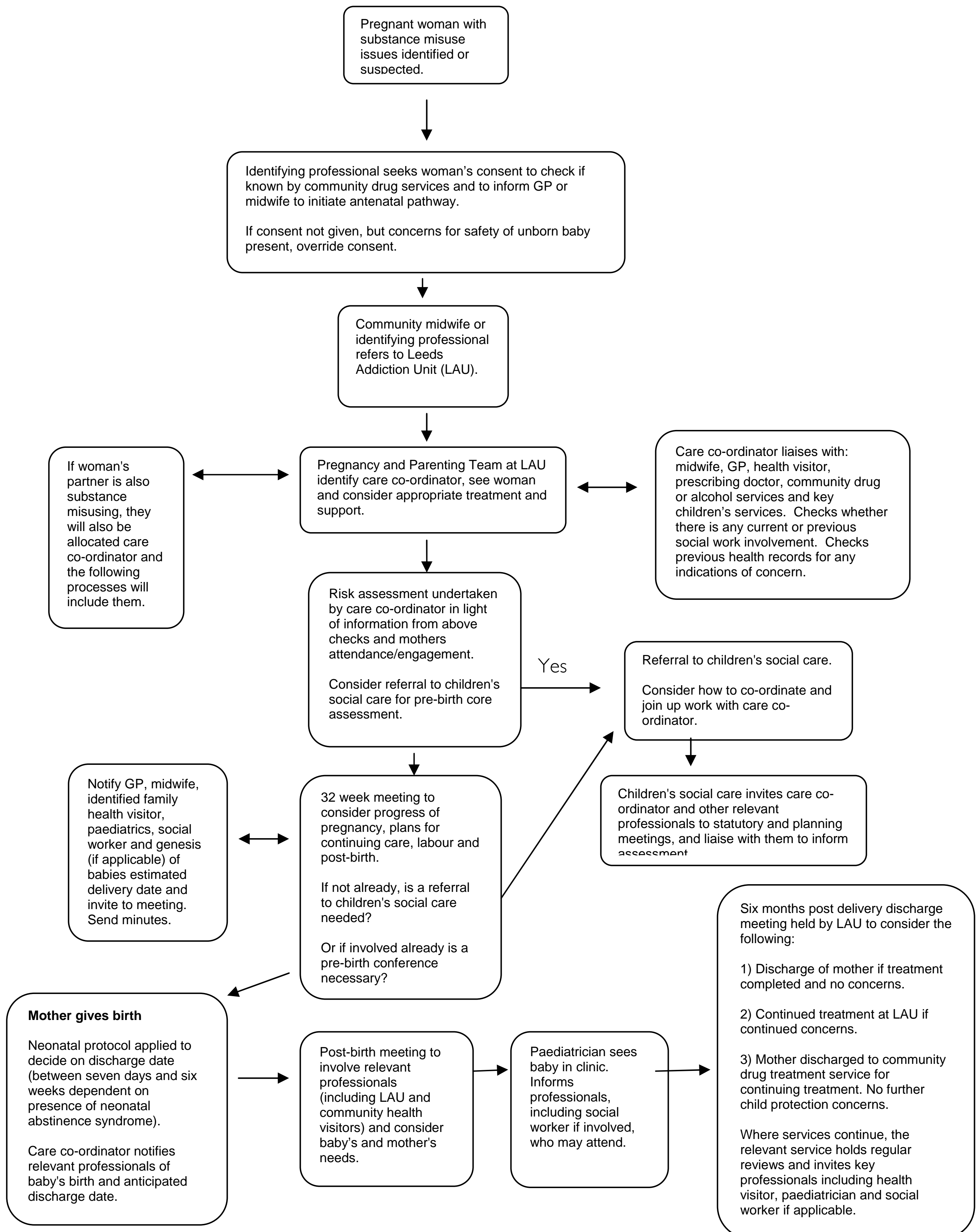
When alerted, consider impact on child and need for contact arrangements, support, information and explanation to the child of the situation.

Agree arrangements with adult substance misuse worker for:

passing information regarding children and arrangements about them to inpatient staff' and

ensuring support for parenting role is included in discharge planning and aftercare plans.

Protocol for joint working with substance misusing pregnant women



Joint working in specific circumstances

Parental mental health problems

Introduction

Definition and scope

For the purposes of this protocol, 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.

Impact on children

When a parent or carer has mental health problems it does not necessarily have an adverse impact on their children. However, it is essential to assess the implications and to consider whether the child's needs are being fully met and whether they are at risk of harm immediately or over time if their circumstances remain the same.

Children in these circumstances are at greatest risk when:

- the child features within parental delusions of hallucinations;
- 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);
- the parent is affected by both mental health problems and substance misuse; 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.

To read the full report go to:
http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59898

Other examples of how children can be affected by their parent's mental health problems include the following.

- Parental mental health problems, over time, can lead to neglect of both the child's basic physical care needs and the home environment.
- The level of supervision, stimulation, guidance and boundaries provided to the child can be adversely affected, impacting upon their development and emotional wellbeing.
- Parental irritability or aggression can be directed towards another family member, which the child may witness or get caught up in.
- Parents with a diagnosed personality disorder may be prone to impulsive behaviour such as aggression or deliberate self-harm, which can impact on any child in their care.

As a consequence of the above:

- the child's attendance or ability to concentrate at school may be reduced;
- the child may take on a caring role for their parent resulting in increased emotional and physical demands on them;
- the child may think the situation is their fault, experience significant; anxiety about their situation and be worried about their own current or future mental health; and
- the child may be, or feel, isolated from their peers because of their situation.

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.

- 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 don'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 parent's problems or inbetween times of difficulty

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

- A confiding relationship with a supportive partner or other who understands and promotes the child's needs
- The absence of parental conflict
- Parental self-esteem
- Social life and routines that promote enjoyment and stability
- Positive coping strategies and deliberate actions by parents to minimise the impact of problems on their children
- Receiving effective treatment
- Openness and good communication
- An understanding of their child's needs and how to minimise harm to them

The following two lists are adapted from Sawyer, E, *Building Resilience in Families under Stress: supporting families affected by parental substance misuse and/or mental health problems* (2009).

When assessing the impact of parental mental health problems on children, it can be helpful to consider the following issues;

- What are the identified risks, strengths and protective factors?
- What are the parent's symptoms, and how is their behaviour and attitude affected by their mental health problems? What might be the impact of this on the child when acute or chronic?
- What is the child's day-to-day experience like currently, and what changes do they experience at other times?
- Is the parent pregnant?
- Is the other parent/carer's attention and capacity to provide for their needs diverted by the needs of the ill parent? How is this affecting the child?
- What are the current/previous concerns of family members or any professionals about the impact of mental health problems on parenting or on the child?

Procedures for joint working with families affected by parental mental health problems

When both adult mental health services, including those in primary and secondary care, and children's services are working with members of the same family, in addition to following the practice guidelines on pages 9-14 of this protocol, it is vital to do the following.

No major decisions, such as the removal of children, closure of a case or moves to discharge a parent from hospital, should be made without the consultation of the other key services, unless immediate action is needed. In these circumstances, other parties should be informed as soon as possible (1).

Contingency planning should take place with workers from both services, considering together how a change in circumstances will be identified and communicated. For example, mental health relapse, failure to maintain medication, change in family dynamics/relationships, increases in stress (2). Ideally, such contingency planning should be documented in the service user's crisis plan in addition to other appropriate locations.

Parts of these procedures, indicated below by bracketed numbers, are taken and adapted from:
(1) Camden and Islington Mental Health and Social Care Trust *Joint Mental Health and Child Protocol* (2005); and
(2) Central and North West London Mental Health NHS Trust *considering the welfare of children whose primary carer has mental health needs: practice guidance for adult mental health practitioners* (2004).

Additional advice is available to practitioners within primary care, who work with service users with substance misuse/alcohol issues and mental health issues.
Go to: http://dual-diagnosis.org.uk/

Expectations of adult mental health services

- Mental health workers, including both those in primary and secondary care, should provide information to Children and Young People's Social Care (or a lead professional in children's services if applicable) including copies of care plans and FACE risk assessments. They should also provide information about the likely duration and prognosis of mental health problems, and the impact of any mental health problem and medication on the parent or carer's general functioning.

- Mental health professionals should attend and provide information to relevant statutory Children and Young People's Social Care meetings including, strategy meetings, child protection conferences, core groups and Looked After Children (LAC) reviews. They should also try to attend any children's services non-statutory meetings that may be useful.

- Adult mental health services should discuss with service users who are parents inviting key staff from other services to Care Programme Approach (CPA) meetings (such as CAMHS, health visitors, children's social workers, voluntary services working with the family) and discuss with the service user their communication with those professionals outside of the CPA process. If the parent does not agree to the children's professionals being invited to their CPA meeting, the care co-ordinator will discuss their objections with them and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the children's social worker or another relevant children's professional to attend part of the meeting. Alternatively, staff should consider holding a joint professionals meeting to review the situation together.

- The health visitor should be invited to all CPA meetings when the service user has a child under five years, irrespective of whether or not the child is known to Children and Young People Social Care or has a children's services lead professional.

- Minutes of CPA meetings must be sent to all key professionals involved and put on the respective case files.

- If there are no concerns regarding the child or parenting issues, record this and continue to include consideration of the child's needs and parental issues in the care plan at every review.

- The children's social worker must be informed of any changes in treatment, such as a trial on reduced or no medication, or if other information comes to light that might have relevance to the parent's progress and overall parenting capacity, such as a drug screen coming back positive.

Parent is admitted to hospital because of their mental health problems

- When any adult is admitted to an acute psychiatric ward the professionals involved in admitting them must attempt to acquire the minimum information.

- Discuss with any involved children services as early as possible when it has been identified that admission may be required.

- In the period prior to admission, professionals should ensure that contact is made with the person who is likely to be caring for the child at home, in order to ascertain any immediate support need. If there is not another suitable parent or carer in the home who can take 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. Any uncertainty among medical staff regarding whether to proceed with a referral to Children and Young Peoples Social Care regarding the child should be discussed directly with CYPSC or the Leeds Partnership Foundation Trust (LPFT) safeguarding team.

- If professionals become aware of families entering into private 'fostering arrangements' and they have any concerns or a lack of information about the suitability of those arrangements, they should alert CYPSC or the children's services lead professional if applicable, so that they can conduct or organise a welfare check.

- Children's or community mental health professionals involved prior to planned or emergency admissions should ensure information on children and arrangements for their care is passed to ward staff.

- Professionals should also consider together and with the parent and child, the need to maintain contact between parent and their child during the treatment period. They should facilitate visits or other forms of contact in a way which is safe and suitable unless the decision has been made and recorded that it is not in the child's best interests. Please refer to the Leeds Partnership Foundation NHS Trust 'Children visiting psychiatric wards' policy: http://www.leedsmentalhealth.nhs.uk/_documentbank/EIA_children_visiting_Psychiatric_Wards_Policy.pdf

- 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 a lead professional from children's service, if applicable, should be invited to meetings.

- There must be ongoing communication between children's and adults' professionals, including consideration of the support needs of the other carer and the child, and decisions about who is best placed to explain the admission to the child and how.

- Ensure the CPA care plan contains support to the parent with their parenting role and a support plan for children, and it considers that plan in the event of a crisis in contingency plans.

- Ensure that both the discharge summary and the FACE risk assessment (updated prior to discharge) contain information regarding any safeguarding concerns, both current and previous.

If the service user is looked after in the community

- Ensure ongoing communication between all adults' and children's professionals and services involved.

- The safety and welfare of the child should be kept under constant review and consideration should be given to involving specialist child-care services.

Expectations of children's services

- If there are concerns about a parent's mental health, check whether the adult is know to mental health services through the GP or the community mental health team (CMHT). Referrals should be made, including a verbal discussion and written information as required, to the relevant CMHT duty team.

- Routinely record whether a parent has a mental health problem and if the adult does not meet the threshold of the CMHT. Then 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.

- 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.

- Children and Young People Social Care must invite mental health professionals to statutory meetings and core groups, and consider inviting them to non-statutory meetings if useful.

- Send minutes of meetings to key adults' services and mental health professionals.

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

Pregnancy

Perinatal mental health problems are common. Many are serious and can have long-lasting effects on maternal health and child development. Suicide has been identified as a leading cause of maternal death, and maternal mental illness is associated with an increased risk of harm to children and of infanticide. Perinatal mental health problems include not only new episodes of mental illness, but also relapses and recurrences of pre-existing psychiatric illness. Perinatal mental health problems present a spectrum of diagnoses and severity and present and are managed at all levels of healthcare provision. The perinatal period is one of role transition, and it is crucial that services are able to work together to meet the needs of mentally ill mothers and their families during this time.

The overwhelming majority of milder conditions are managed within primary care, by maternity services, social care and voluntary agencies. The Leeds Perinatal Mental Health Service is for women with more severe or complex difficulties, or where their difficulties have not been resolved within primary care.

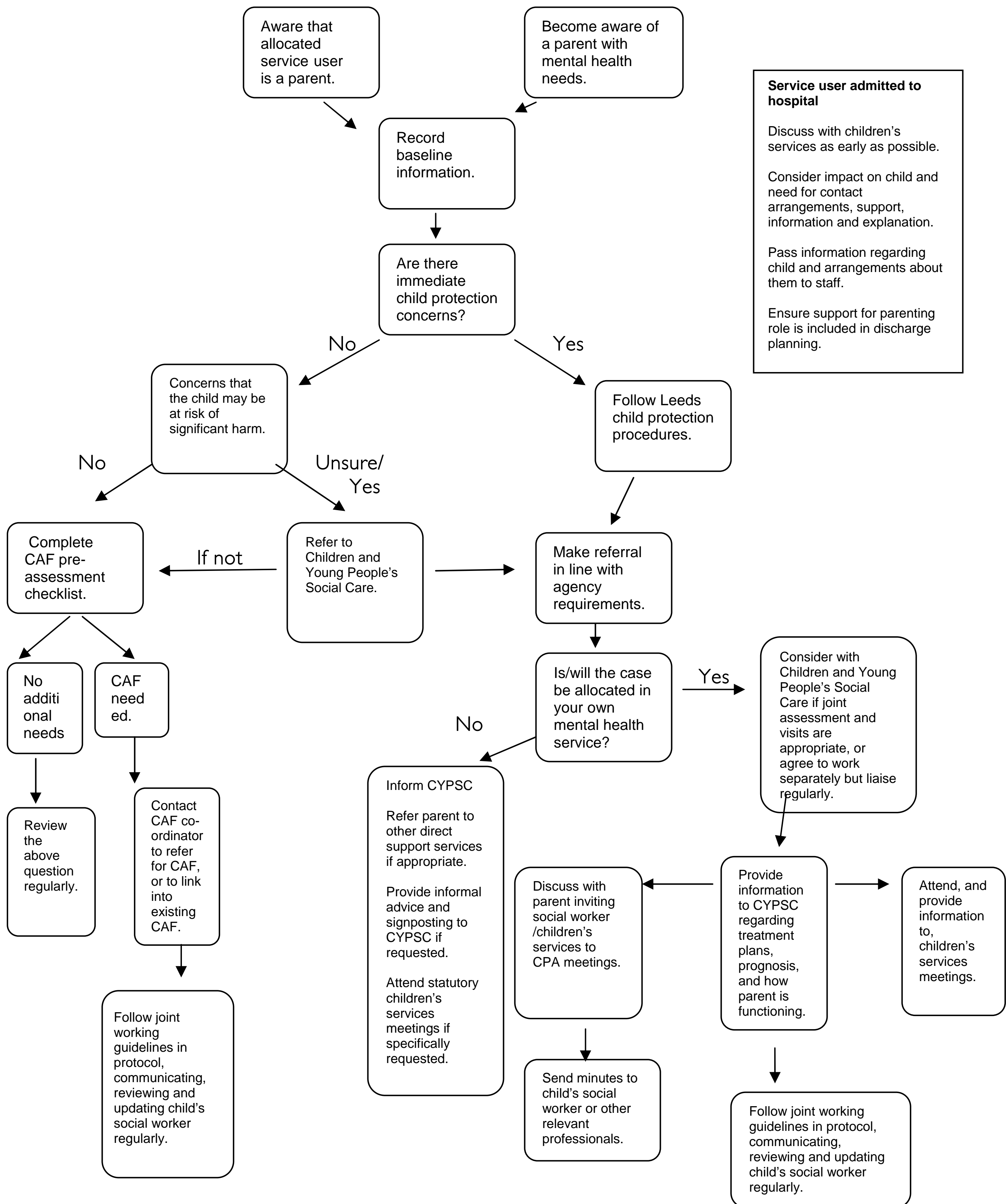
The Leeds Perinatal Mental Health Service is comprised of:

- four-bedded mother and baby in-patient unit;
- community outreach and liaison service; and
- outpatient and assessment clinics.

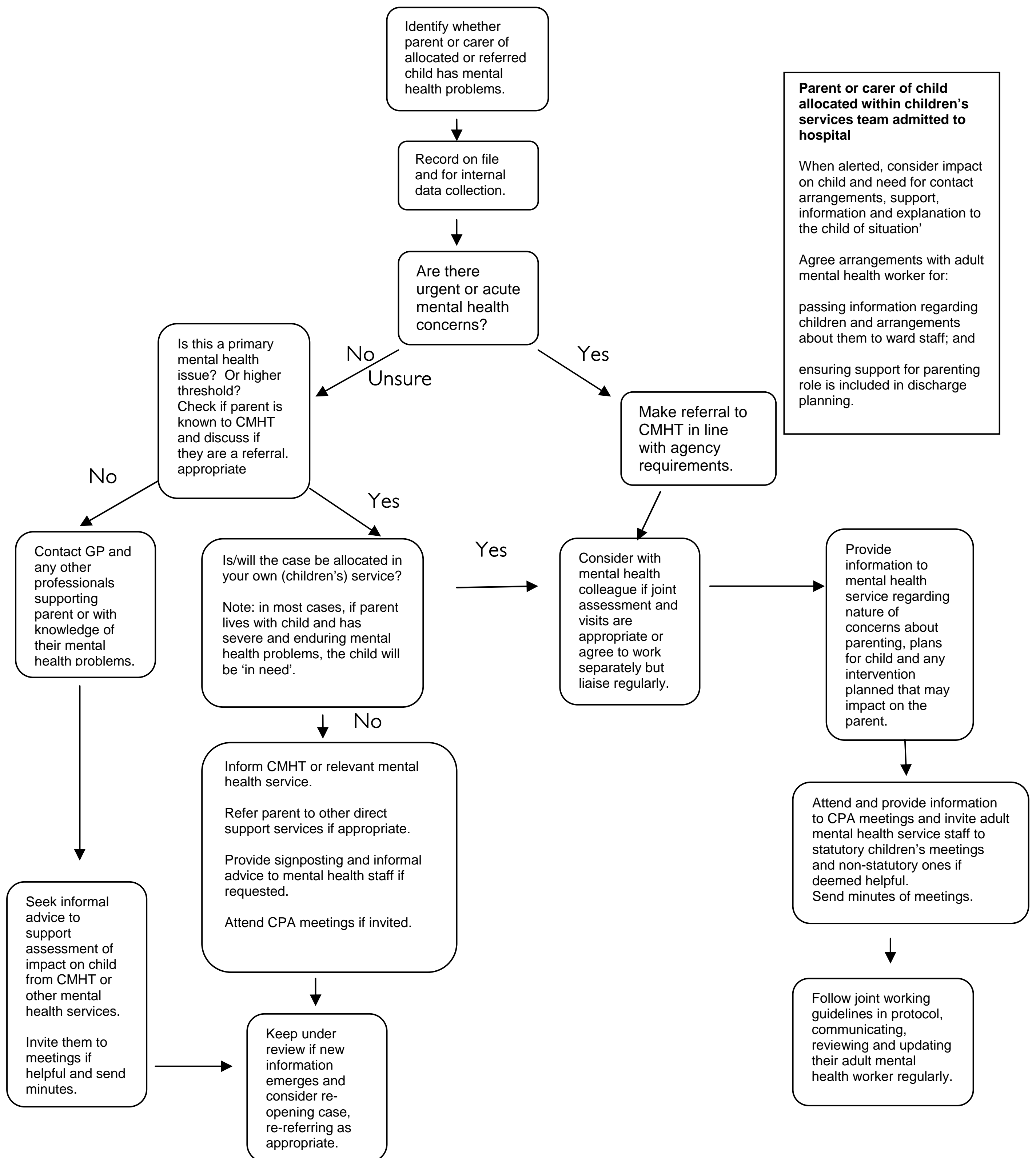
The four-bedded mother and baby unit provides a service for Leeds mothers, and will also accept out-of-area referrals if a bed is available. It provides for joint admissions for the mother together with her child. There is also provision for the admission of pregnant women who are either suffering from significant mental illness or are at high risk of a rapid deterioration in mental state following giving birth.

The aim of the unit is to treat the mother's illness whilst maintaining and promoting the mother-child relationship, often in the presence of severe mental illness. Its approach allows the mother to provide as much care as she is able for her child whilst ensuring a safe therapeutic environment for both the mother and her child.

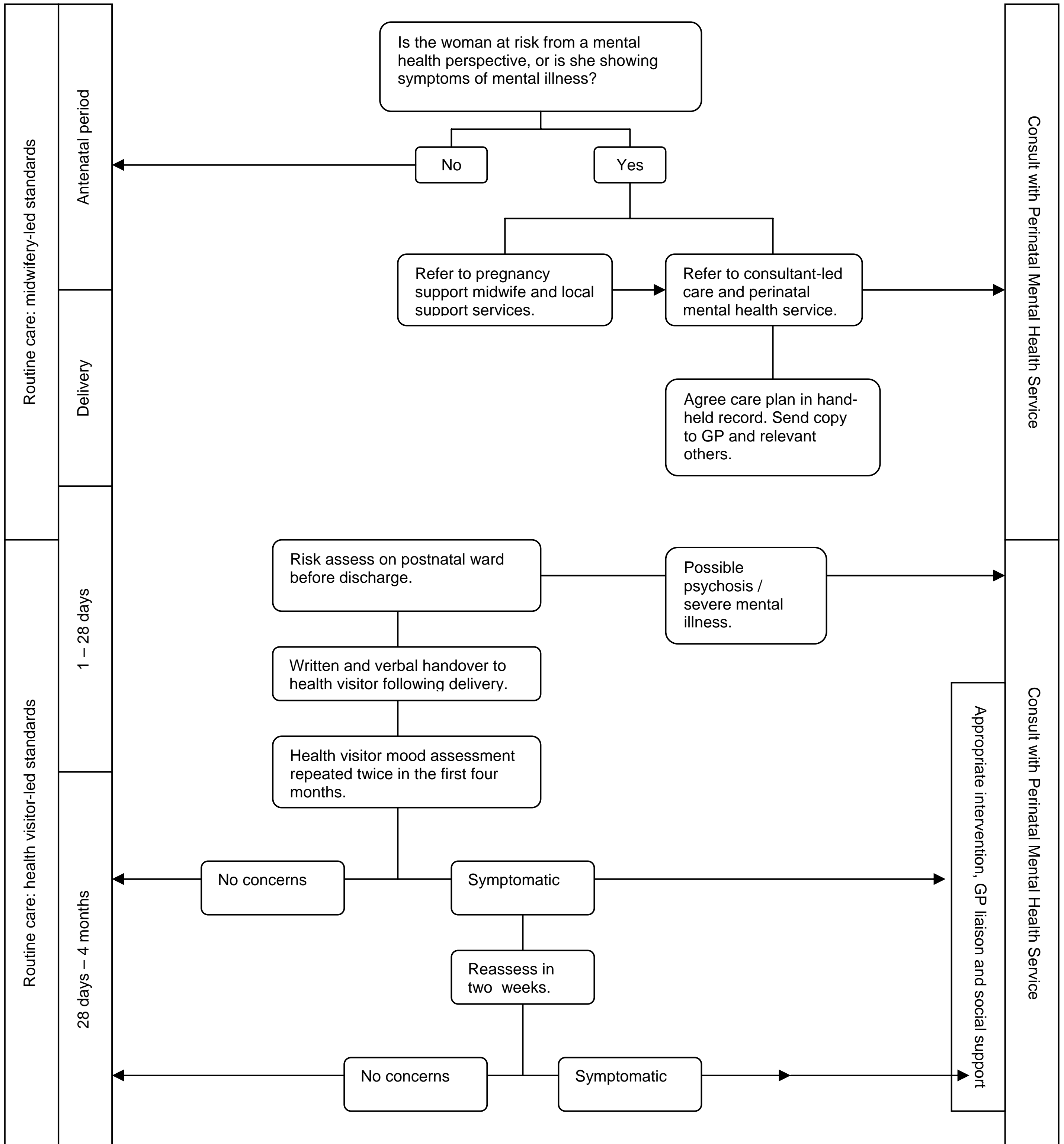
Protocol for adult mental health services working with parents



Protocol for children's services working with parents with mental health problems



Perinatal mental health integrated care pathway



Glossary

Adults' services

Adults' services is a generic term for all services that are responsible for arranging services for anyone who is 18 or over and has difficulty due to old age, long-term illness or disability, mental health problems or substance misuse, or who has a caring role.

Bipolar disorder

Bipolar disorder is where there is presence of one or more episodes of abnormally elevated mood clinically referred to as mania. Individuals who experience manic episodes also commonly experience depressive episodes or symptoms, or mixed episodes of both mania and depression at the same time. These episodes are usually separated by periods of "normal" moods.

Child and adolescent mental health services (CAMHS)

CAMHS provide multidisciplinary mental health services to all children and young people with mental health problems and disorders, to ensure effective assessment, treatment and support for them and their families. CAMHS is often used as a broad concept that embraces all services that contribute to the mental health care of children and young people, whether provided by health, education, social services or specialist mental health agencies. However, sometimes, as in this protocol, CAMHS is used more narrowly to refer to specialist child and adolescent mental health services; in other words, services operating at tiers 2, 3 and 4 of the four-tier strategic framework.

Care programme approach [CPA]

A CPA aims to provide the basis for systematically planning the care of people with mental health needs outside hospital. It applies to all people with serious mental health problems who are clients of specialist mental health services. CPA comes into play while someone is a psychiatric hospital in-patient (not necessarily detained under the Mental Health Act), and creates the framework for discharge planning and aftercare.

Children and Young People's Social Care Services (CYPSC)

CYPSC provide help for children with significant needs, who are at risk of abuse, who have disabilities or special needs, are care leavers, are a risk to themselves or to others, and who cannot live at home with their families.

Children in need

Under the Children Act 1989, a child is defined as being a child in need if:

- they are unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for them of services by a local authority;
- their health or development is likely to be significantly impaired or further impaired without the provision of such services; or
- they are disabled (Section 17/10 Children Act 1989).

Community Mental Health Team (CMHT)

A CMHT is made up of people from different professional groups who work with people with severe or enduring mental health problems. This includes community mental health nurses, home support workers, psychiatrists, social workers and a physical health nurse advisor.

Common Assessment Framework (CAF)

The CAF is a standardised approach to conducting an assessment of a child's additional needs and deciding how those needs should be met. It can be used by practitioners across children's services in England. It provides a simple, standardised process for making a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development.

Co-morbidity/Dual Diagnosis

This refers to the concurrent presence of more than one disorder, for example, mental illness and substance misuse.

FACE

FACE is a comprehensive risk assessment and risk management tool that is designed to be used by mental health and older people's services.

General Practitioner (GP)

A GP is a medical practitioner who provides primary care. A GP treats acute and chronic illnesses, and provides preventive care and health education for all ages and both sexes.

Improving access to psychological therapies (IAPT)

This aims to improve access to evidence-based talking therapies in the NHS through an expansion of the psychological therapy workforce and services.

Lead professional

The lead professional takes the lead role in co-ordinating provision, and acts as a single point of contact for a child and their family when a range of services are involved and an integrated response is required. Appointing a lead professional is central to the effective frontline delivery of services for children with a range of additional needs. In the context of multi-agency assessment and planning, underpinned by the CAF or relevant specialist assessments, the lead professional ensures that professional involvement is rationalised and co-ordinated.

Perinatal services

These provide support and treatment to women who are either at risk of, or are affected by, mental illness during pregnancy or the first post-natal year. The service is provided by working in partnership with other providers to ensure that care is given at the most appropriate level.

Personality disorder

This is disorder characterised by the chronic use of mechanisms of coping in an inappropriate, stereotyped, and maladaptive manner. Personality disorders are long-standing and maladaptive patterns of perceiving and responding to other people and to stressful circumstances.

Primary care mental health services

Mental health services can be provided through a GP, other primary care services or through more specialist care. This might include counseling and other psychological therapies, community and family support or general health screening. For example, people experiencing bereavement, depression, stress or anxiety can get help from primary care or informal community support. If they need more involved support they can be referred for specialist care.

Resilience

This refers to the capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity and to do better than might be expected in light of their experiences.

Schizophrenia

This is a mental illness characterised by abnormalities in perception or expression of reality. It most commonly manifests as auditory hallucinations, paranoia or bizarre delusions. Onset of symptoms typically occurs in young adulthood.

Significant harm

The Children Act 1989 defines significant harm as where there is ill treatment or impairment of health or development;

- 'Ill treatment' includes sexual and emotional abuse as well as physical abuse.
- 'Health' includes physical and mental health.
- 'Development' includes physical, intellectual, emotional, social and behavioural development.
- 'Significant Harm' turns on the question of the harm suffered by a child in respect of its health and development compared with the health and development reasonably expected of another child.
  (Sec 31(10) Child Act 1989)