

Joint Working Protocol

Safeguarding children and young people whose parents/carers have problems with:

mental health, substance misuse, learning
disability and emotional or psychological
distress

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“Safeguarding children is everyone’s responsibility. Everyone who comes into contact with children and families has a role to play” (Working Together 2013)

Most parents and carers have the capability to provide good or good enough parenting for their children most of the time. Sometimes, a usually capable parent will have such overwhelming needs of their own that they may not have the capacity to be such a capable parent. This protocol supports early intervention work that can make a real positive difference to the outcomes for children and their families. The value and importance of this multi-agency early help for families, and the shared responsibility for its provision, is recognised and supported by the [Munro Review 2011](#).

This multi-agency protocol has been written for every person, staff or volunteers, (hereafter called practitioners) working with people whose complex problems might impact on their ability to care for children and for those working with children whose parents or carers have those complex problems.

It gives information about research and guidance for good practice. Parts 1 and 2 should be read by all: parts 3-5 giving more specific information to be used depending on particular needs within the family.

Although not an exhaustive list, it should be read by every practitioner, engaging with children, adults or families, in or as:

- Adult Services
- Advocates
- A&E Departments
- Allied health professionals
- Ambulance services
- Armed Forces welfare
- CAMHS
- Children’s Centres
- Children’s Social Care
- Citizens Advice Bureaux
- Counselling services
- Domestic Abuse services
- Early years’ settings
- Fire & Rescue services
- GPs & practice nurses
- Health Visitors
- Housing & support providers
- Learning Disability services
- Medical Practitioners
- Mental health services
- Midwives
- Pharmacists
- Police
- Probation
- Prison
- Rape Crisis services
- Refuges
- Schools & Colleges
- School Nurses
- Substance misuse services
- Voluntary organisations
- Youth Offending Teams

If your concerns are about immediate neglect or harm to a child, whether emotional, physical or sexual, the Local Safeguarding Children Board (LSCB) child protection procedures should be followed without delay. www.4lscb.org.uk

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All documents or sites available on the internet are hyperlinked.

Key Messages

If you are working with adults who have mental health, substance misuse, learning disability problems or emotional or psychological distress, you must make sure that any children in their care, or who they come into contact with, are considered.

You must liaise with Children's Social Care if the children are at risk of harm, using the [Local Safeguarding Children Board \(LSCB\)](#) procedure without delay.

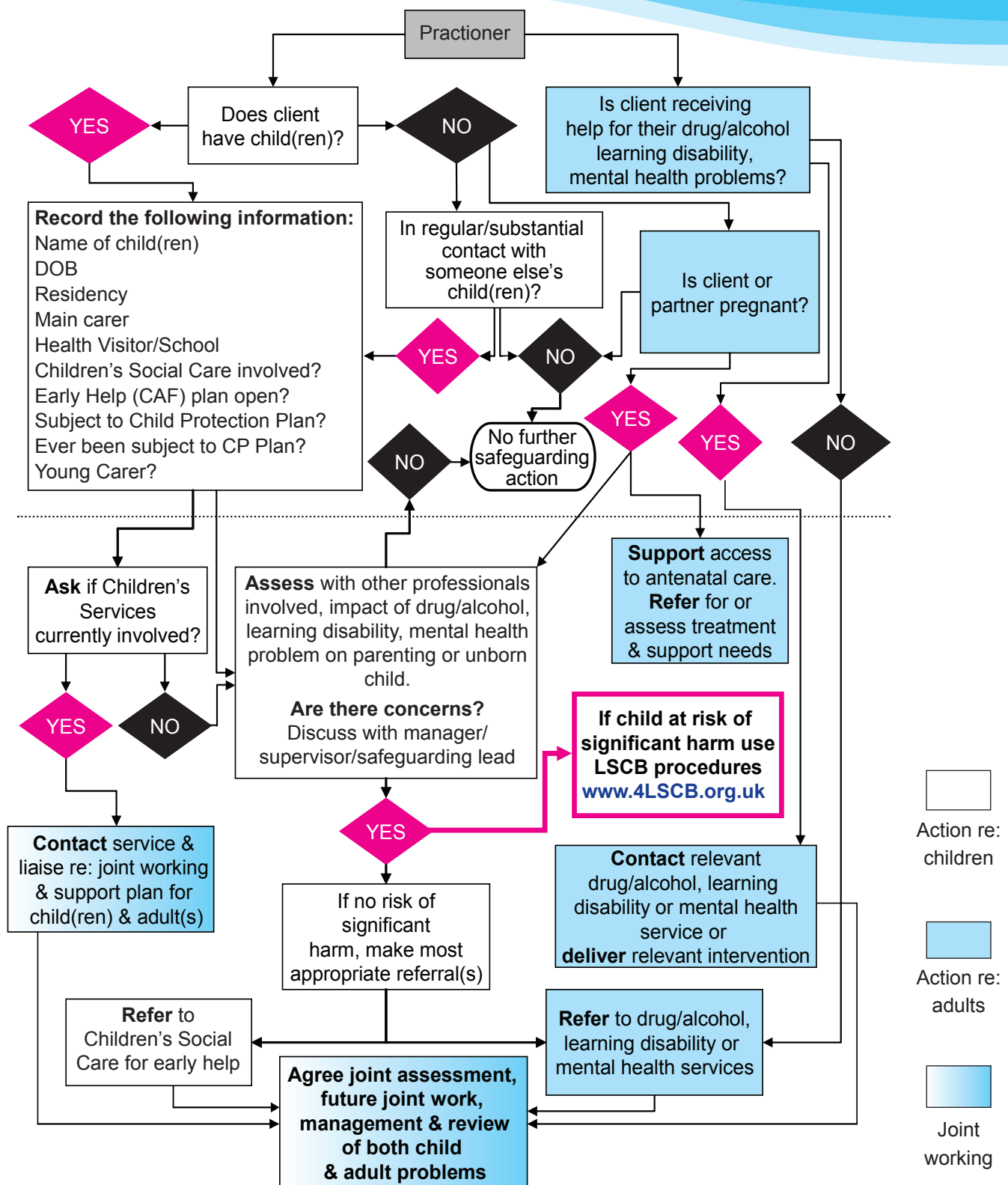
If the risks are lower, you should communicate with other workers who might be or need to be in contact with the children, using this procedure.

The LSCB, your professional bodies and employers require you to do this.

- Practitioners working with adults must identify and record at the earliest stage:
 - the adult's relationship with any children
 - any parenting or caring responsibilities for children
 - which other agencies they need to work with if they have concerns about unborn babies, children or young people.
- Practitioners should discuss any concerns they have with the family before making a referral to Children's Social Care, unless this discussion places the child at increased risk.
- Data protection should not be used as a barrier to appropriate information sharing.
- Risks to a child's safety or welfare may only become apparent when several people share concerns which contribute to a larger picture of risk.
- Safeguarding issues escalate Fair Access to Care eligibility to critical/substantial.
- Mental health, substance misuse and learning disability problems can increase the risk of harm to children, especially when combined with domestic abuse.
- If a service user expresses delusional beliefs involving their child and/or they may harm the child as part of a suicide plan, a referral to Children's Social Care must be made immediately.

- If a practitioner feels that a person may be at risk from an untreated psychosis they must alert the GP in order for the GP to arrange a mental health assessment.
- Changes in family circumstances should trigger a re-assessment of risk to children.
- If, after referral, practitioners remain concerned about the safety of a child, they should report their concerns to a supervisor/manager who must ensure concerns are resolved appropriately.
- Supervision, guidance and support from managers &/or specialists in safeguarding children are essential for people working with adults in contact with children.
- It is important to hear the 'voice' of the child.
- Young carers need to be identified as caring can have detrimental effects on young people's education, health and emotional well-being.
- Any concerns about the safety of adults must be referred through the relevant Safeguarding Adult procedures.

Flowchart



Part 1: Introduction

1.1 PURPOSE

1.1.1 To safeguard and promote the welfare of children and young people, including young carers, whose lives are affected by parent/carers using drugs/alcohol or by parents/carers with mental health problems, learning disabilities, or other complex problems e.g. acquired brain injury, progressive neurological conditions, that may adversely affect their ability to parent or care;

To promote effective communication between adult drugs/alcohol, mental health, learning disability, primary GP and community health care (health visitor, school nurses), universal services, other services and Children's Social Care;

To set out good practice for the services involved to enable working together in the assessment and care planning for families with problematic substance use, mental health, learning disability or other complex problems and to ensure their full participation in the process whenever possible.

In the context of this protocol 'parents/carers' includes anyone who has access to the child, for example, members of the extended family and friends or acquaintances.

The term 'children' refers to those aged 0-18 years of age. The needs of unborn babies must also be considered and it must not be assumed that teenagers are not harmed or can advocate for themselves.

1.2 SCOPE

1.2.1 This protocol has been written for use by the many statutory, non-statutory, voluntary, independent/private sector and primary care services working with parents/carers who may have mental health, learning disability, drug/alcohol or other complex problems.

It has been written by a multi-agency group with representatives from the many voluntary, statutory and non-statutory agencies that provide services to the residents of any of the 4 LSCB areas (Hampshire, Isle of Wight, Portsmouth and Southampton). It has been informed by consultation that included child and adult services users. The document has been ratified by the 4 LSCBs.

All services represented on the 4 LSCBs will be expected to know of the existence of this protocol and be able to recognise when it should be used. Partner agencies must ensure that this protocol is disseminated widely within their organisation and that they seek assurance that front line staff have read it, particularly during induction, and are using it appropriately ([Hampshire multi-agency case review AG](#))

1.2.2 All practitioners are expected to use this protocol when they come into contact with:

- an adult with drug/alcohol, mental health or learning disability issues or other complex problems, who is caring for, or has significant contact with a child
- a child whose life is affected by a parent/carer's use of drugs/alcohol or who has mental health, learning disability or other complex problems.

This should also include any other adults living in the same household as children. Practitioners working with adults should identify and record at the earliest possible stage the adult's relationship with and caring responsibilities for any children.

1.2.3 It is important to note that this protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering harm. If the concerns are about immediate neglect or harm, whether emotional physical or sexual, to the child, the [4LSCB Safeguarding Children](#) child protection procedures must be followed without delay.

1.2.4 If there are concerns about the safety of a vulnerable adult, the relevant Safeguarding Adult procedure should be used.

1.2.5 This protocol sits at a level of secondary prevention in terms of the standard categories of prevention, where a quick response is required to prevent low level problems from getting worse. At times low level signs may be 'the tip of the iceberg' and an early discussion, referral or joint assessment may prevent more serious harm or neglect of a child. [Munro review of child protection: interim report - the child's journey](#) (page 23)

1.2.6 **Risks to a child or young person's safety or welfare may only become apparent when several people share what they may consider to be a minor concern but which contributes to a larger picture of risk that no single person or agency has access to.**

1.2.7 Parenting at any stage, from pregnancy to when the child becomes an adult at eighteen, can be a challenge for any parent or carer, requiring a great deal of physical and emotional effort. Most parents and carers have the capacity to provide good or good enough parenting for their children most of the time and are able to access universal services to support their health, education and leisure needs.

This protocol should be used if and when a usually capable parent has such overwhelming needs of their own that they may not have the capacity to be such a capable parent.

If this is short term, such as a parent being physically ill, then providing the physical and safety needs of the children are met, most children have the resilience to overcome the stress of this with the support of their friends and family. The protocol may need to be used if the issues continue for longer or frequent periods of time or the additional support is not available to the child.

1.3 BACKGROUND

1.3.1 History of the protocol

1.3.1.1 The protocol came into existence in 1999, following the death of a baby whose mother was known to mental health services. It was revised in 2004 after publication of [Hidden Harm](#).

In 2008 a further revision took place involving extensive consultation, including with young people.

1.3.1.2 The 2011 revision included a new section on parents with learning disability; a requirement of a Serious Case Review (SCR) in 2009, following serious injury to a baby whose mother had a learning disability and following recommendations arising from Lord Laming's review of the protection of children.

1.3.2 Key statutory duties

1.3.2.1 Local authorities have specific duties under the [Children Act 1989](#) in respect of children in need (Section 17) and children at risk of significant harm (Section 47).

1.3.2.2 [Section 11 Children Act 2004](#) places duties on organisations working with adults and children with substance use/misuse, mental health and learning disability problems in health, social care and voluntary sector settings to safeguard children when they become aware of or identify a child at risk of harm, following LSCB procedures which are based on the Government Guidance [Working Together 2013](#).

1.3.2.3 [Carers \(Recognition and Services\) Act 1995](#) states that young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring.

1.3.2.4 [Carers \(Equal Opportunities\) Act 2004](#) states that identification of young carers can be problematic. Many children live with family members with stigmatised conditions such as mental illness and/or drug and alcohol problems. In many cases, families fear what professional intervention may lead to if they are identified. Some families may also have concerns about stigmatisation of being assessed under children's legislation.

1.3.2.5 The [Disability Discrimination Act 2005](#) makes it unlawful for agencies to treat disabled people less favourably, so in the context of this protocol, they must ensure that they do not treat children with disabilities less favourably than other children with regard to safeguarding.

1.3.2.6 The [UN Convention on the Rights of the Child](#) states:

- Children have the right to live. Governments are responsible for making sure every child grows up healthy.

[\(Article 6: Survival and Development\)](#)

- Children have the right to live with their parent(s) unless this is not in their best interests. Children who do not live with their parents or whose parents are separated or divorced have the right to remain in contact with both parents unless this is not in their best interests.

[\(Article 9: Separation from Parents\)](#)

- Governments should make sure that children are appropriately cared for and are not being physically, psychologically, or sexually abused or neglected by their parents or other caregivers.

[\(Article 19: Protection from Child Maltreatment\)](#)

- Children with disabilities, such as physical, emotional, cognitive, or developmental impairments, are entitled to all the rights prescribed in this Convention. Governments should ensure that these children receive the care and support they need in order to lead full, independent lives.

[\(Article 23: Children with Disabilities\)](#)

1.4 KEY PRINCIPLES

1.4.1 Confidentiality and information sharing

1.4.1.1 **Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children.** To ensure effective safeguarding arrangements:

- all organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the LSCB

- **no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe.** If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care.

[\(WT2013 p15\)](#)

1.4.1.2 It is critical that **all practitioners** working with children and young people are in no doubt that where they have reasonable cause to suspect that a child or young person may be suffering significant harm or **may be at risk of suffering significant harm**, they should always refer their concerns to Children's Social

Care. While a practitioner's primary relationship may be with the parent, where there is cause for concern, information needs to be shared on a 'need to know' basis with the appropriate Children's Social Care.

- 1.4.1.3 “You do not need to be certain that the child or young person is at risk of significant harm to” (to tell an appropriate agency) “...the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause” [Protecting children and young people: The responsibilities of all doctors. \(General Medical Council, Sept 2012\)](#)
- 1.4.1.4 Practitioners should seek to discuss any concerns with the family and, where possible, seek their agreement to making referrals to Children's Social Care to optimise the care of the children and protect them from harm. **This should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm.** The child's interest must be the overriding consideration in making any such decisions.
- 1.4.1.5 However, where a child is not suffering, nor at risk of suffering significant harm, parental permission is needed for the sharing of information. This should be raised with parents at the beginning of professional involvement following agency guidelines, with emphasis on the help and support which can be accessed by the family as a result of sharing information with other agencies. In general, information sharing is in the best interests of the person and supports delivery of effective treatment. It is important to take into consideration their wishes and feelings and attempt to understand the nature of their daily lived experience. ([Lord Laming](#))
- 1.4.1.6 Everyone should ensure that the information they share is proportionate and necessary for the purpose for which they are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely way and is shared securely. If in doubt, seek advice; this may be done without disclosing the identity of the person.
- 1.4.1.7 Consent or the refusal to give consent to information sharing about children should always be recorded. For further information see [Information Sharing: Guidance for practitioners and managers \(HM Government, 2008\)](#), the aim of which is to support good practice in information sharing by offering clarity on when and how information can be shared legally and professionally, in order to achieve improved outcomes.

See Appendix 1 for **7 Golden Rules for Information Sharing**.

1.4.2 Confidence to act

Although the following quote comes from guidance for doctors, it is applicable to all practitioners. **“It is vital that all doctors have the confidence to act if they believe that a child or young person may be being abused or neglected. Taking action will be justified, even if it turns out that the child or young person is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable, and the doctor takes action through appropriate channels.”** [Protecting children and young people: The responsibilities of all doctors](#)

- 1.4.2.1 For useful guidance for everyone on how to make effective referrals to Children’s Social Care see the Department of Health’s 2013 [SAFER communication guidelines for Health Visitors](#).
- 1.4.2.2 Recent local Serious Case and Multi-Agency Case Reviews have noted the need for practitioners to escalate their concerns (individually or through their manager/supervisor) if they feel action has not been taken yet their concerns remain. This is echoed by [Marion Brandon et al](#) in the [New learning from serious case reviews 2009-11](#), who also states that practitioners must not make assumptions about actions others will take or fail to follow through on cases to ensure actions are taken. Similarly, [Lord Laming](#) talks about the importance of ‘**respectful challenge**’ of parents, colleagues and professionals in other agencies if practitioners feel that action is not being taken or is insufficient to safeguard a child.
- 1.4.2.3 If it becomes apparent that a change of circumstances has occurred or the parent is not complying with services and this raises concern about the welfare of the child or there is a concern that the child is at risk of significant harm, practitioners must make a referral to Children’s Social Care or other agencies in order that a re-assessment of the situation and appropriate action can be taken. These concerns may include:
- [failure to attend for appointments](#)
 - [failure to allow access for home visits](#)
 - [avoidance of practitioners](#)
 - [change in treatment](#)
 - [homelessness or family network breakdown](#)
 - [deterioration in mental health, physical health, more chaotic substance misuse](#)
 - [introduction of a new adult, child or young person into the home situation or someone leaving the home situation](#)

1.4.3 Equalities

- 1.4.3.1 This protocol applies in all situations irrespective of the race, gender, age, sexual orientation, class, cultural and religious beliefs or disability of those involved.
- 1.4.3.2 In order to make sensitive and informed professional judgments about a child's needs, and the capacity of parents/carers to respond to those needs, professionals should be sensitive to differing family patterns, lifestyles and child-rearing practices which can vary across different racial, ethnic and cultural groups. **However, all professionals must be clear that child abuse or neglect, caused deliberately or otherwise, cannot be condoned or dismissed on religious or cultural grounds.**
- 1.4.3.3 All professionals will be aware of stereotypes and prejudices which exist about adults who use drugs /alcohol or have mental health needs or a learning disability, similarly about children who have disabilities. It is essential that these do not influence assessments. Any assessment should be thorough, based on observation of and discussion with the parents and children involved and should be undertaken jointly, or at least discussed with, relevant specialist workers (in voluntary, statutory or private sector) whose views should be taken into account.

1.4.4 Child-centred

- 1.4.4.1 "Effective safeguarding systems are child-centred". ([WT2013](#))
- 1.4.4.2 "Where there is a conflict between the needs of the child and their parents/carers, decisions should be made in the child's best interests." ([WT2013](#))
- 1.4.4.3 Practitioners should be aware that some children may be what Brandon, in the latest review of SCRs, describes as '**invisible**' due to:
- appearing to thrive in the positive school environment
 - presenting as healthy, clean and well cared for, masking underlying distress
 - their own resilience, hiding the trauma they are experiencing
 - a focus on a single 'problem child' in a family
 - a focus on parental issues, without considering the impact on the child
 - practitioners not seeing or speaking to the child
 - practitioners not hearing/recognising what the child tries to say or show.

1.4.5 Whole Family Working

- 1.4.5.1 In a system that 'Thinks Family', services for both adults and children join up around the needs of the family and set out what this system would look like to families on the ground. [Think Family: Improving the Life Chances of Families at Risk, 2008](#)
- 1.4.5.2 Universal services such as health, housing and education, have a key role in identifying children and adults with additional needs and signposting families to specialist or other universal services. Practitioners in specialist adult services dealing with vulnerable parents should be alert to the needs of children and young people and think **"who do I need to work with?"** within services for children to help identify or meet their needs. This means that all those working with children, young people and their families are potentially involved in providing early help and/or intervention work in safeguarding children and their families to prevent harm.
- 1.4.5.3 Unless it places children at increased risk, it is important to engage with and involve families to reduce risk of harm to children. Evidence from help lines indicates "the possibility of seeking advice without losing control of what happens next is a way in which some children and families move towards seeking a service." [C4EO Safeguarding Briefing 1, Nov 2009](#)
- 1.4.5.4 Although written for doctors, this is applicable to all practitioners. "Doctors should work with parents and families, where possible, to make sure that children and young people receive the care and support they need. But in cases where the interests and wishes of parents may put the safety of the child or young person at risk, doctors must put the interests of the child or young person first. Failure to act when a child or young person is at risk can have serious consequences for both the child and their family." [Protecting children and young people: the responsibilities of all doctors](#)
- 1.4.5.5 When conducting initial assessments within your own agencies, always identify which other agencies might be involved in the care of the family, to provide a full picture.

1.4.6 Partnership Working

- 1.4.6.1 Safeguarding and promoting the welfare of children, and in particular, protecting them from significant harm, depends upon effective joint working.
- 1.4.6.2 Sharing information is essential to enable early identification to help children, young people and families who need additional services to achieve positive outcomes. See [What to do if you're worried a child is being abused](#) (DfES 2006)
- 1.4.6.3 Systems should be in place to ensure that:
- managers working with adults can monitor those cases which involve dependent children
 - there is regular, formal and recorded consideration of such cases with Children's Social Care practitioners
 - if adults and children's services are providing services to a family, practitioners communicate and agree interventions
 - adult services can contribute to common assessments of need (Munro), such as CAF and Team Around the Child meetings sharing their knowledge of the parent/carer and parenting capacity
 - appropriate practitioners are invited to relevant planning meetings
 - practitioners participate in the relevant planning meetings.

[Pan Hampshire Safeguarding Children Procedures](#)

1.5 Commitment from Services

1.5.1 Children's Social Care

- 1.5.1.1 Children's Social Care will receive and record contacts expressing concerns about risks to children. They will be clear with other agencies about their threshold for involvement and give feedback on what will happen as a result of a contact. They will be open to having discussions with other services regarding their concerns. See [LSCB](#) websites for local thresholds.
- 1.5.1.2 All contacts about concerns will be recorded, whether they trigger an assessment or not, and in the event of subsequent referrals being received, will contribute to building a picture of issues and concerns which may trigger further action, which will be fed back to referring agencies.
- 1.5.1.3 Throughout their involvement with children and their families, Children's Social Care **will**:
- focus on the needs of the child
 - assess the unborn child's needs and identify desired outcomes for the child
 - assess the child or young persons needs and identify desired outcomes for the child
 - ensure that the wishes and feelings of child/ren are ascertained

- ensure the child is given the opportunity to be seen/heard on their own, but be aware that the child's view of 'normality' and what is acceptable may be influenced by exposure to drug or alcohol abuse, or other factors (e.g. domestic abuse). Workers may need to take actions that are contrary to the views of the child but are required to protect them
- employ a policy of openness with families where information from other agencies impacts on planning for the child
- seek consent from family members to share information with other agencies in the best interests of the child (but bear in mind this should only be done if the discussion and agreement-seeking will not place a child at increased risk of significant harm) – see 1.4.1.4
- be clear whether an assessment using the Common Assessment Framework (CAF) or alternative early help assessment has been undertaken, and if so, its outcomes
- liaise with substance misuse teams where there is evidence or suspicion that parents are using substances and make sure that the assessment includes fathers, partners and all relevant adults, not just the mother [Engaging with men in social care: a good practice guide \(Fatherhood Institute & Family Rights Group, 2013\)](#)
- consult with primary and secondary mental health services, learning disability and substance misuse teams for information to support assessment of parenting capacity, and for realistic assessment of any risk even where there are no apparent safeguarding issues, undertaking joint assessment where possible
- invite representatives from mental health, learning disability and substance misuse services to Child in Need Planning Meetings and Child Protection Conferences where they are involved with the family
- together with relevant agencies, identify roles and responsibilities for any on-going work with the family: a meeting is preferable where decisions need to be made and owned.

1.5.2 **Services working with adults including GPs**

1.5.2.1 Through their involvement, services working with adults **will**:

- identify at an early stage any children within families and specifically adults with a caring responsibility and other adults in contact with children
- ensure, when assessing adults' needs, that the adult is seen in terms of their parenting role as well as an individual and that any support to help their parenting role is taken into account. Liaison with services for children will be required
- understand that although parental mental ill-health, learning disability or substance misuse, especially in combination with domestic abuse, does increase the risk that children may be harmed, it is not a predictor of harm or neglect

- invite representatives from Children’s Social Care or other services to multi-professional care planning meeting where they are involved with the family, with the agreement of the service user
- provide a representative to attend Child Protection Conferences or other planning meetings where at all possible and/or provide a report
- ensure they are kept informed about plans for any children and incorporate these into future care planning.

1.6 Case Management

1.6.1 Effective inter-agency communication and multi-agency co-operation is **crucial** to the management of on-going work with people with mental health, learning disability, substance misuse or other complex problems and their families. There must be clarity with regard to the different roles and responsibilities undertaken by different workers and a decision made regarding co-ordination, so that this is not left to the parent.

1.7 Planning Meetings

1.7.1 Early Help Assessment/Common Assessment Framework (CAF)

1.7.1.1 The CAF provides a process for identifying children’s needs and bringing services together to meet those needs more quickly and effectively.

1.7.1.2 Each agency/organisation will have its own system with regards to undertaking an Early Help Assessment or CAF. If there is uncertainty about using the assessment, advice should be sought from the relevant Children’s Social Care Department or the safeguarding children leads in the organisation.

1.7.1.3 Parents should be asked if an Early Help Assessment or CAF has already been done and if so, who is the Lead Professional.

1.7.1.4 Each LSCB area is responsible for developing a process for providing families with early help to prevent escalation of need. This process will be outlined within the relevant Thresholds document and guidance, available on the [LSCB website](#).

1.7.2 Other planning meetings

1.7.2.1 Practitioners should be aware of any other plans around family members e.g. Children in Need planning, Core Group, Team around the Child (TAC), MAPPA (Multi-Agency Public Protection Arrangements) , MARAC (Multi-Agency Risk Assessment Conference), CPA (Care programme Approach) and other multi-professional planning meetings and ensure they are involved in those processes.

1.7.3 **Child Protection Conferences (4LSCB procedures)**

- 1.7.3.1 Child Protection Conferences will be conducted in line with LSCB child protection procedures and the Children's Social Care Department Safeguarding procedure. It is expected that representatives from the appropriate statutory and voluntary agencies will attend Conferences, and if they cannot, that they will provide a deputy. They must supply the Conference Chair with a written report in time for the Chair to read and understand the case. Representatives may also be required to attend Core Group meetings, where detailed plans to protect children are made, following the Conferences.
- 1.7.3.2 GPs have a particularly important role to play because they hold key information regarding the family. They are the single point for holding an individual's health information and usually the first point of contact for a person with the health service. They are expected to attend and/or submit a report for the Child Protection Conference (as above).
- 1.7.3.3 Parents and, where appropriate, children and young people, are encouraged to attend Conferences. They may be excluded, however, if they are under the influence of substances at the time of the Conference to such an extent that they are unable to participate effectively. Children may be offered an advocate to accompany them or speak for them to represent their views.
- 1.7.3.4 Parents are invited to bring someone to support them or an advocate to the Conference. Their key worker from the Drug/Alcohol, Mental Health or Adult Services team will always be invited to attend by the social worker where the needs of parents are seen to potentially impact on the child. The key worker will be part of the professional network and will be expected to contribute to the decision-making and be clear as to what their service can offer to meet the needs of the child as part of the Child Protection Plan.

1.8 **Supervision**

- 1.8.1 It is crucial that all agencies establish a clear framework for supervision, guidance and support.
- 1.8.2 Supervision, guidance and support from managers and/or specialists with knowledge of safeguarding children is essential for people working with children, parents or carers. Concerns about children must be raised in formal supervision and any informal discussions or telephone advice must be followed up in supervision.

“To work with families with compassion but retain an open and questioning mindset requires regular, challenging supervision”.

Munro Review of Child Protection Part One: A Systems Analysis

1.8.3 Those supervising practitioners working with adults should always ask about the care of children in the family and those managing child care cases should always ask about collaboration with adult workers if there are drug or alcohol misuse, mental health or learning disability problems affecting parents.

1.9 Training

1.9.1 There are statutory requirements under [Section 11 Children Act 2004](#) for organisations to ensure that practitioners working with adults, who may have parenting responsibilities, should receive safeguarding children training appropriate to their role. [Working Together 2013](#) states that practitioners in universal services should have access to training to identify and respond early to abuse and neglect. Similarly staff in early years' services should complete safeguarding training under [Section 40 Childcare Act 2006](#).

1.9.2 There should be awareness-raising regarding this protocol in every relevant agency, with training related directly to this protocol ideally multi-agency. Research by [Carpenter, J et al](#) on behalf of the DCSF in 2009 [Outcomes of Interagency Training to Safeguard Children](#) showed that multi-agency safeguarding children training was particularly useful and valued by practitioners.

Appendix 1

7 GOLDEN RULES OF CONFIDENTIALITY

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Extract from HM Government [Information Sharing: Guidance for practitioners and managers](#)

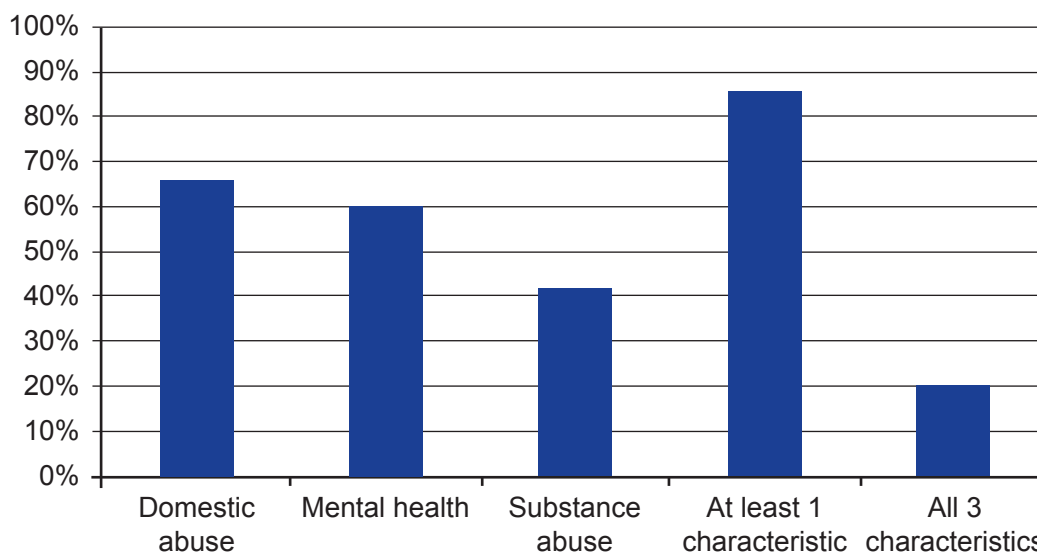
Part 2: General guidance for all

2.1 RISK

“Risk management cannot eradicate risk; it can only try to reduce the probability of harm”.

Munro Review of Child Protection: Part 1 - A Systems Analysis

- 2.1.1 The risks particularly associated with mental health, substance misuse and learning disability are dealt with within their specific sections. The risks for the children and parents are known to increase considerably when these factors combine with each other or with domestic abuse, often referred to as the ‘toxic trio’.



Characteristics evident in 115 in SCRs [New Learning from Serious Case Reviews 2009-11 \(Brandon, M et al, DCSF\)](#)

- 2.1.2 The same review identified that neglect was a background factor in 60% of the cases, including in 11 out of the 14 cases where a young person was thought to have committed suicide.
- 2.1.3 A new factor identified by the same review was the young age of the mother when her first child was born (60%) and the potential cumulative stresses and risks of harm as these mothers had more children.

- 2.1.4 Assessing these risks is important and requires the practitioner not only to rely upon any standard risk assessment used in their particular field but to think broadly about risks to others and how these may be lessened through joint working. It is also important to attempt to assess the resilience factors the child may have.
- 2.1.5 Family members and other children living with a person with complex problems may be assessed as being a protective factor for a child. Whilst their opinion of risk is important, practitioners must assess the risk independently, as the family member may be too entrenched in the circumstances to be able to give an objective view.
- 2.1.6 [New Learning from Serious Case Reviews 2009-11](#) states “that if a parent presents with self harming or suicidal ideation or behaviour, the risks of harm to both parent and child should be taken very seriously indeed.” Evidence from SCRs in this period suggests that being a parent may not be as protective a factor as had previously been thought.
- 2.1.7 ...”children are likely to be placed at greater risk through:
- Failure to identify important males in children’s lives (especially when the man is living in another household)
 - Inadequate understanding of the roles fathers and other men play in the lives of at-risk children
 - Poor assessment of the risks posed by some men
 - Failure to challenge risky behaviour enough – pressuring mothers to manage the risk or get the men out
 - Failure to strengthen men’s positive contributions to their children’s wellbeing.
[Engaging with men in social care](#)
- 2.1.8 Most children and young people who are seriously harmed or killed are not involved with specialist mental health or probation services and subject to their risk assessments. They are more likely to be receiving help and support through universal services such as those offered through GPs, health visitors, school nurses, walk-in centres, schools, voluntary sector or local council services, such as housing.
- 2.1.9 However, [Munro & Rungay \(2000\)](#) in [Role of risk assessment in reducing homicides by people with mental illness](#) argue that more homicides could be prevented by good mental health care, which detected relapse earlier. This includes those involving deaths of children.
- 2.1.10 The circumstances of people’s lives and health can change frequently meaning that the stresses and risks both for individuals and the family also change and need frequent holistic re-assessment.
- 2.1.11 Practitioners should be wary of being too optimistic as the child’s situation can deteriorate once support is removed. ([WT2013](#))

2.2 PSYCHOSIS

2.2.1 A number of SCRs (i.e. Hackney, [Child A & Child B Exec Summary](#), Birmingham [Child case 14](#)) have highlighted the risk that some people with psychosis can be to their children; in rare cases leading to Filicide.

In the Hackney SCR, the mother had believed the children were not her own, having been swapped at birth. In the Birmingham SCR, the father appears to have had delusional beliefs, linked to his faith beliefs, leading to the failure to provide care for his child.

Having parents with psychosis can lead to emotional stresses in a family, which can have a negative effect on children in the family home.

2.2.2 Practitioners from any agency may observe people with psychosis.

They may be experiencing:

- **hallucinations** – where people see, hear, smell, taste and feel things that are not there
- **delusions** – where people have fixed false irrational belief; this may be paranoid, believing others may wish to harm them or their family
- **thought disorder** – where people speak quickly and incessantly (pressure of speech) or switch topic mid-sentence (flights of ideas) or make irrational statements, believing things around them have changed in some way.

Early signs of psychosis may include:

- odd or bizarre behaviour
- severe deterioration of social relationships, social withdrawal or isolation
- inappropriate laughter, unexplained euphoric mood, feelings of depression or anxiety.

2.2.3 Psychosis is a symptom of a variety of conditions, which can include mental illnesses, such as schizophrenia or bipolar disorder, but can also be associated with drug or alcohol misuse and sometimes with physical conditions, such as Parkinson's disease.

For some, a period of psychosis will last only a few days, for others, if untreated, it can last for long periods. Some people only experience one episode of psychosis throughout their lives, while others may have several. Most psychosis is treatable.

2.2.4 If any practitioner believes that the person may be suffering from a delusion involving their children, which includes non-abusive thoughts, they **must** make a referral to Children's Social Care.

If any practitioner believes a person may be at risk to children through other forms of psychotic ideas i.e. hallucinations, they **must** also make a referral to Children's Social Care.

2.2.5 It is important that if a practitioner feels that a person may be at risk from an **untreated** psychosis they alert the GP in order for the GP to arrange a mental health assessment. This includes if the person is unwilling or unable to seek help themselves. In some situations the GP can arrange an assessment under the Mental Health Act 1989, as amended 2007, if they believe the person to be a risk to themselves and/or others.

2.2.6 Children and young people can also develop a psychosis. Comprehensive help is provided for people with psychosis throughout the area covered by this protocol. Assessing it is usually by a GP referral, however Early Intervention in Psychosis Teams accept self referrals and work with people from age 14-35 years.

2.3 PARENTAL TREATMENT – IMPACT ON CHILDREN

2.3.1 Consideration of the needs of parents in relation to access to treatment e.g. for their substance misuse or mental health problems, should be seen in the wider context of the effect on the whole family. Whilst accessing treatment is a positive step for the parent, it may have a negative impact on children; for a child it may mean taking on more caring responsibilities for their parents, both practically and emotionally or separation from a parent.

2.3.2 Building on the [National Treatment Agency Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services 2013](#) workers need to consider:

- does the parent need childcare support to access treatment?
- what care arrangements need to be in place for the parent to access hospital, a detox/rehab unit or home detox?
- who is offering the child support?
- inclusion of a plan for the care of the child in the adult's crisis or contingency plan
- will the parent need support getting the child to and from nursery/school?
- liaison with school or early years service
- what is the child's understanding of the parent's treatment, does the parent need support in explaining what will happen?
- referral to young carers services for the child carer (see section 2.4)
- referral to Children's Social Care if they consider the child may be at risk of harm
- referral to Children's Social Care if a child is likely to be cared for outside their immediate family for more than 28 days ([Private Fostering](#))

2.3.3 Practitioners should also be aware that successful treatment of parents, allowing them to resume their caring responsibilities, might mean a loss for the child of the role they had previously undertaken or a change in the dynamics of the relationship between the child and parent which may have an adverse effect on the child.

2.4 YOUNG CARERS

2.4.1 “The term ‘young carer’ should be taken to include children and young people under 18 who provide regular or on-going care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances ...a young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well being or educational achievement and life chances.”

2.4.2 Young carers’ guidelines apply “no matter how competent or willing a young carer may appear to be. They apply equally whether care needs arise as a result of mental or physical illness or disability, substance misuse and whether a parent or a sibling is the focus of support.” [Working together to support young carers and their families](#) (ADASS/The Children’s Society/ADCS MOU template, August 2012).

2.4.3 There are 166,363 young carers in England according to the [2011 Census](#). This is likely to be an under-estimate as parents rather than children completed the questionnaire and no mention was made of some conditions, such as substance misuse or HIV.

According to the Children’s Society report [Hidden from View 2013](#) young carers:

- may be as young as 5 years old
- have substantially lower GCSE attainment than their peers
- live in households with an average income of £16,000, which is £6,000 lower than their peers
- are 1.5 times more likely to come from a BME community than their peers
- are 1.5 times more likely to have a special educational need or disability than their peers
- are more likely to be NEET (not in education, employment or training) than the national average

However, despite evidence of need, they are no more likely to be in contact with support agencies than their peers.

2.4.4 For services to provide effective support for young carers and their families, it is vital that all practitioners working with them begin with an inclusive, wide-ranging and holistic approach that considers the needs of:

- the adult or child in need of care
- the child who may be caring and
- the family

- 2.4.5 Young carers identified the following concerns:
- gaps in the support of the person they cared for and the wider family
 - impacts on their own wellbeing, personal development and education and pressures on their everyday lives
 - lack of recognition by the NHS, GPs and schools about their needs as children who are also young carers
 - the need for closer joint working across adult social care and children’s services to ensure better outcomes for children and the person who is supported [Carers at the heart of 21st century families and communities, June 2008](#).

2.4.6 [Recognised, Valued and Supported: next steps for the carers strategy, 2010](#) states “The onset of mental health problems and the process of seeking help can be particularly traumatic for families. Those supporting people with mental health, personality disorder or substance misuse problems can be wary of seeking help outside the family because of the stigma, discrimination and bullying that are still too often associated with these conditions. Many young carers remain ‘hidden’ from health, social care and education services – partly as a result of those services needing to do more to identify them but also because of family fears that they will be taken into care or because the young people themselves are concerned about the reactions of others and bullying by their peers.”

“A whole family approach will also minimise the risk of young carers feeling forced into undertaking inappropriate caring roles.”

“Young carers have said that often services focus on the adult in front of them without thinking through the implications of the disability, mental illness or substance misuse problem on the children of the family. This can lead to a child taking on a harmful caring role.”

2.4.7 School nurses and their teams deliver the Healthy Child and public health programmes for children and young people aged 5-19, both in and out of schools. This includes support to young carers. ([Getting it right for children, young people and families, March 2012](#)).

2.4.8 For details of your local young carers service please see the map on the following link. <http://www.youngcarer.com/young-carers-services>

2.5 CHILDREN WITH DISABILITIES

2.5.1 Children with disabilities have exactly the same rights to be safe from abuse and neglect and to achieve their potential as non-disabled children.

2.5.2 “Disabled children can be abused and neglected in ways that other children cannot and the early indicators suggestive of abuse or neglect can be more complicated than with non-disabled children”.

- 2.5.3 “Having a disability must not mask or deter an appropriate enquiry where there are child protection concerns”. [Safeguarding disabled children practice guidance \(DfES 2009\)](#)
- 2.5.4 Difficulties to be aware of when considering whether a child with a disability is being abused include:
- indicators of abuse being seen as part of the child’s disability (e.g. challenging behaviour, skin complaints, shyness, enuresis)
 - failure to see the child’s needs as separate from their parents’ needs (i.e. seeing the disability and its effects on the family, not seeing the child)
 - over-identification with parents/carers (i.e. accepting neglectful situations which would not be accepted in non-disabled children due to sympathy for parents)
 - beliefs that disabled children are not abused
 - bruising in a place easily explained by equipment in use or moving and handling requirements
 - being exposed to a greater number of adults/others providing personal and intimate care
 - lack of stimulation
 - unjustified/excessive use of restraint
 - insufficient help with feeding which could lead to malnourishment
- 2.5.5 Although limited, American research has shown that children with disabilities are 3.4 times more at risk of being abused than non-disabled children and are more likely to experience multiple abuse. ([PM Sullivan and JF Knutson, Maltreatment and disabilities: a population-based epidemiological study](#). However, the [Children in Need census 2010-2011](#) suggests they are less likely to become the subject of a Child Protection Plan.
- 2.5.6 What is apparent is that children with disabilities are more dependent on their parents and carers for day-to-day personal care, ensuring they live in a safe environment and in accessing services they require. The impact of neglect on children with disabilities is significant and according to Ofsted’s [Protecting disabled children: thematic inspection 2012](#) the risks are not always recognised in time.
- 2.5.7 Children with disabilities may also be more vulnerable to abuse due to their lack of understanding of what abuse is, their trust in adults and through being less able to express their views or worries.

2.6 CHILD SEXUAL EXPLOITATION

2.6.1 The [Office of the Children's Commissioner](#) identified, in its [Inquiry into Child Sexual Exploitation in Gangs and Groups](#), the need for all practitioners to be aware of the warning signs of child sexual exploitation:

- going missing for periods of time or regularly coming home late
- regularly missing school or education or not taking part in education
- appearing with unexplained gifts or new possessions
- associating with other young people involved in exploitation
- having older boyfriends or girlfriends
- suffering from sexually transmitted infections
- mood swings or changes in emotional wellbeing
- drug and alcohol misuse
- displaying inappropriate sexualised behaviour

For further information see [4LSCB](#) website

2.7 PSYCHOLOGICAL OR EMOTIONAL DISTRESS

2.7.1 In addition to mental health, substance misuse and learning disability, the following situations, which may cause psychological or emotional distress, are associated with increased risks to the whole family and for most will require support from friends, family and possibly services:

- transitions and unexpected life events such as separation, divorce, bereavement, discharge from prison, return to civilian life from armed forces – on leave from active service or at the end of service
- social isolation
- hate crime
- pregnancy
- financial difficulties

2.7.2 Domestic abuse

2.7.2.1 Approximately 130,000 children were living with domestic abuse and approximately 1.2 million females and 800,000 males were victims of domestic abuse in 2011/2012. In 2010/2011, repeat victimisation accounted for 73% of all incidents of domestic violence; 44 % were victimised more than once and 24% of victims had been victimised three times or more. ([caada - co-ordinated action against domestic abuse - Statistics, 2013](#))

2.7.2.2 Domestic abuse is defined by the Home Office 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.

This definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.”

2.7.2.3 Domestic abuse frequently co-exists with child abuse. It rarely exists in isolation and may contribute to drug and alcohol misuse and poor physical and mental health. Parents may also have a history of poor childhood experiences themselves, including growing up with domestic abuse between their parents. Domestic abuse compounds the difficulties parents experience in meeting the needs of their children and even if there is no physical violence, it has been shown to have a serious negative impact on children and young people at each stage of their development, leading to health, behavioural, educational and social difficulties.

2.7.2.4 The presence of domestic abuse in a family increases the likelihood that children and young people will experience abuse and/or neglect. The risk of physical harm to both the victim and children increases around the time of separation and may continue as subsequent contact arrangements are made.

2.7.2.5 From January 2005 the legal definition of harm to children was extended to include the impairment suffered from seeing or hearing the ill treatment of another – particularly in the home, even though they themselves have not been directly assaulted or abused. ([Adoption and Children Act 2002 Section 120](#)). In 75-90% of incidents with domestic violence, children are in the same or next room. ([Munro review of child protection: interim report - the child’s journey](#)).

For detailed guidance see [Safeguarding Children Abused through Domestic Abuse in the 4LSCB procedures](#) [4LSCB](#)

2.7.3 Parents who offend

2.7.3.1 All agencies should be aware of the impact of a prisoner returning to the family home. Additionally, there is specific guidance for Police and Courts around arrest and sentencing of offenders with responsibilities for children. ([Around Arrest, Beyond Release. Experiences and needs of Families in Relation to the Arrest and Release of Drug Using Offenders, August 2007, Tackling Drugs, Changing Lives](#))and [Around Arrest, Beyond Release 2 Moving Forward](#).

2.7.3.2 Within HMP Winchester there has been a project to support prisoners in their role as fathers, to strengthen family relationships and to increase the stability of the children's lives to enable them to achieve positive outcomes. Partners in this project are the Prison, Local Authorities, Probation, Sure Start Children's Centres, Job Centre Plus and Spurgeons.

2.7.4 Parents who kill their children

2.7.4.1 Parents who kill or seriously harm their children are not always known to services. In analyses of SCRs over the years it has been found that approximately 50% of the cases were not known to Children's Social Care but they may have been known to other services for children or adults.

2.7.4.2 Men are more likely to kill their children than women. The additional risk factors for men appear mixed and may relate to:

- being a violent individual or previously known to commit violent crimes
- being a perpetrator of domestic abuse
- undergoing, or there being a threat of, separation from a partner
- being emotionally distressed and having difficulties that bring feelings of loss, shame or hopelessness. This may be associated with emotional difficulties, prior abuse or linked with loss of work, housing difficulties or money worries. This may be linked with suicide.

2.7.4.3 Although such murders are unpredictable, many are thought to be pre-meditated. It is therefore important to offer additional support to fathers, recognising the importance of their role within the family. [The National Confidential Inquiry into Suicide and Homicide by people with a Mental Illness, 2009](#).

2.7.4.4 Babies are particularly vulnerable; [The Home Office statistical bulletin: homicides, firearm offences and intimate violence, 2010/11](#) states that children under one year old were the age group most at-risk of homicides, with 25 homicides per million population compared to the overall victim risk of 11.5 per million population.

2.7.4.5 There is a higher proportion of infanticide by females after the time of a baby's birth. This appears to be related to puerperal psychosis or the mother being unable to face the reality of being pregnant or a mother (see Section 3.3)

- 2.7.4.6 Most of the SCRs identified sources of information that could have contributed to a better understanding of the children and their families. This included information about or from fathers and extended family, historical knowledge, information from other agencies, the cultural background and research findings. [Learning lessons from serious case reviews 2009-2010, Ofsted.](#)
- 2.7.4.7 Learning from SCRs has also highlighted the need to identify if family members are being supported by different GP Practices, as a result of personal choice or urgency. If this is the case, then effective information sharing needs to be prioritised if concerns are raised. ([Hampshire SCB SCR Child Q](#))

Appendix 2

Further reading/resources

- NICE Clinical Guideline 89 When to suspect child maltreatment: December 2009, updated March 2013
- SCIE Guide 30 Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009
- No health without mental health, HM Government, February 2011
- No health without mental health Implementation framework, July 2012
- Child & Adolescent Mental Health - YoungMinds
- Barnado's Keeping the Family in Mind: a briefing on young carers whose parents have mental health problems
- Royal College of Psychiatrists resources
- Safer baby guidance Lullaby Trust (formerly FSID)

Part 3: Specific/additional guidance: mental health

3.1 DEFINITION

- 3.1.1 This protocol refers to people with mental health problems, from mild and moderate to severe and enduring mental ill health and including eating disorders and personality disorders. It is important that all practitioners should be aware that the term 'mental health problems' covers a range of illnesses, some requiring brief intervention in primary care, while others require referral to specialist mental health services.

For the purposes of safeguarding children, the mental health or mental illness of the parent or carer should be considered in the context of the impact of the illness on the care provided to the child.

3.2 IMPLICATIONS FOR AND IMPACT ON PARENTING

- 3.2.1 The Royal College of Psychiatrists states that “data indicate that 10-15% of children in the UK live with a parent who has a mental disorder and 28% of those are the children of lone parents with a mental disorder”. [Parents as patients: supporting the needs of patients who are parents and their children CR164, January 2011](#)

They also state that 68% of women and 57% of men with mental illness are parents. [Parental mental illness: the impact on children and adolescents, March 2012](#)

- 3.2.2 “Most parents with mental illness do not abuse their children and most adults who abuse children are not mentally ill.” However, there are well-established links between parental mental disorder and poor outcomes for children. These can be felt from conception onwards and into adult life. [Parents as patients: supporting the needs of patients who are parents and their children](#)

- 3.2.3 That 2011 guidance offers the following advice:
“Although many parents with mental illness and their children can be remarkably resilient, adverse outcomes for children are associated with parental mental disorder. Hence, psychiatrists and other mental health professionals in any speciality must consider the family context of service users and consider the well-being and safety of any dependent children at any stage of the care process from assessment to discharge. This will involve working closely with other agencies, across boundaries, sharing information as appropriate and remembering that a child’s needs are paramount even in situations where the necessary safeguarding action may impair the therapeutic relationship with the parent.”
- 3.2.4 The mental health of both fathers and mothers and any effect on the child need to be considered. Where both parents have a mental illness, the adverse effects on children may increase.
- 3.2.5 All parents find parenting challenging at times, and those with a mental health need often show considerable inner strength in adequately parenting their child. Being a parent with a mental health need, however, may be particularly challenging. Many parents are painfully aware that their disorder affects their children even if they do not fully understand the complexities. [\(Falkov A \(ed. 1998\) Crossing Bridges: Training resources for working with mentally ill parents and their children. Brighton: Pavilion Publishing\)](#)
- 3.2.6 “Any assessment should measure the potential or actual impact of mental health on parenting, the parent/child relationship, the child as well as the impact of parenting on the adult’s mental health. Appropriate support and ways of accessing it should also be considered in the assessment.” [Parents as patients](#)
- 3.2.7 Parental personality factors (pre-existing and/or exacerbated by the illness) may mean parents have difficulty controlling their emotions, have an inability to cope or be self-pre-occupied. Violent, irrational and withdrawn behaviour can frighten children.
- 3.2.8 The lack of capacity to parent well may not be the only reason for poor outcomes for children whose parents have mental illness. Issues such as poor housing, financial difficulties, domestic abuse, or hostile neighbourhoods may be significant factors in parental stress and illness. [\(Stanley et al \(2003\) Child Protection and Mental Health Services: Interprofessional responses to the needs of mothers. Bristol: The policy Press\)](#)
- 3.2.9 Unmet mental health needs can lead to the child taking on responsibilities beyond their years because of their parent’s incapacity. This may include becoming a carer for the parent and/or other children or family members.
- Children may understand when things are not right and if their needs are not being met. They may not be able to, or want to say anything about it, or there may be no-one to tell; they may just get on with it by taking on inappropriate caring roles for their families. (see young carers, section 2.4)

- 3.2.10 Questions about childcare and parenting issues are clearly sensitive and can have important implications for people with mental health problems. The stigma associated with mental illness may make parents reluctant to ask for help.
- Fear of a child being removed from their care has been expressed by parents as an obstacle to seeking help for their mental health needs or fully engaging with services. Practitioners need to be aware of this fear and should work with the parents and families openly, building on their strengths.
- 3.2.11 Families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas. It is government policy to promote the wellbeing of children through timely and appropriate support.
- 3.2.12 All children, even young children, are sensitive to the environment around them. Thus their parents' state of mind can have an effect on even the youngest child. In this context, all children are vulnerable when a parent has a mental illness but children may be helped considerably where the parent is aware of this. ([Stanley et al., 2003](#))
- 3.2.13 Strengths in the family, such as the protective influence of another adult, can minimise the effects on children of the mental illness of a parent.
- 3.2.14 Identifying the impact of these stresses on the child is an important factor in the initial assessment for the child and the care plan for the parent and reinforces the need to see the mental health needs of parents/carers in the context of family life and functioning.
- 3.2.15 It is essential that an appropriate assessment of the parent/carer's needs is undertaken to assess the impact on any child involved with the family. Children have a right to have their own needs assessed, receive appropriate services and to be heard in their own right so that risk factors can be identified and minimised and protective factors promoted.
- 3.2.16 To safeguard children of parents with whom they are working, mental health practitioners should routinely record details of parent's responsibilities in relation to children and consider the support needs of parents and of the children. This should include consideration of whether the adult is likely to resume contact with a child from whom they have been separated.
- 3.2.17 In General Practice, as a result of personal choice, urgency, inflexible appointment systems or failure to utilise systems appropriately, patients with serious mental health problems may not see the same GP on a regular basis. Where patients with serious mental health problems are referred to the Community Mental Health Team, there needs to be consistency of practitioner and information sharing. **In these cases it is recommended that, where practicable, one named GP monitors the patient's care and receives correspondence.** ([Child Q SCR Recommendation, HSCB July 2010](#))

3.2.18 **In cases where service users express delusional beliefs involving their child and/or they may harm their child as part of a suicide plan, a referral to Children’s Social Care must be made immediately.** [Preventing harm to children from parents with mental health needs](#)

The report details recommendations that must be actioned, the key points of which are:

- are there any children in the household?
- does the service user have contact with children in their working or social network?
- if there is no current contact with children will this be resumed in the future?
- in secondary care, a consultant psychiatrist should be directly involved in clinical decisions if the service user may pose a risk to children.

3.3 **PRENATAL AND POSTNATAL PERIOD**

3.3.1 Specific concerns apply to the pre- and post-natal periods. It is vital that there is joint working between the General Practice, Midwifery, Health Visiting and, if involved, specialist Mental Health Services. It is essential to identify needs, assess and prepare safeguarding plans for both mother and child, using appropriate pre- and post-natal mental health pathways.

3.3.2 Post-natal depression (PND) is very common among new parents and may affect as many as 1 in 6 new mothers, typically in the first 3 months after delivery, sometimes lasting for 6 months or up to a year if left untreated. Maternal post-natal depression can be significantly harmful to young infants particularly from birth to 12 months of age, with increased incidence of insecure attachment. [\(Cox. A.D, Puckering. C, Pound. A, and Mills. M \(1987\) *The impact of maternal depression in young children. Child Psychology and Psychiatry*, vol 22, no 6 pp 17-28\)](#)

[\(Murray. L, Hipwell. A, and Hooper. R, \(1996\) *Cognitive development of 5 year old children of postnatally depressed mothers. Child Psychology and Psychiatry*. vol 37, no 8, pp. 927-35](#)

It is not the depression itself which causes damage, it is its impact on the mother’s ability to interact with and respond to her child. Prolonged non-availability of the primary carer can lead to emotional and cognitive difficulties, social withdrawal, negativity and distress.

3.3.3 [The NICE Clinical Guideline 45](#) page 9 states:

“At a woman’s first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

- During the past month, have you often been bothered by feeling down, depressed or hopeless?

- During the past month, have you often been bothered by having little interest or pleasure in doing things?
- A third question should be considered if the woman answers 'yes' to either of the initial questions.
- Is this something you feel you need or want help with?

3.3.4 Puerperal psychosis is a disorder which affects 1-2 women per 1000. It is potentially a very serious illness often requiring hospitalisation. The onset can be very rapid within hours of birth although it often develops over days, sometimes weeks. Women with an existing diagnosis of Bi-Polar Disorder or who have a close family member with this are at significantly greater risk of developing Puerperal Psychosis and should be referred to a Perinatal Mental Health Service during pregnancy to agree a post delivery management plan.

Appendix 3

Summary of potential impact on child of primary and secondary behaviours associated with parental psychiatric disorder

PARENTAL BEHAVIOUR	POTENTIAL IMPACT ON CHILD (in addition to attachment problems)
Self preoccupation	Neglected
Emotional unavailability	Depressed, anxious, neglected
Practical unavailability	Out of control, self-reliant, neglected, exposed to danger
Frequent separations	Anxious, perplexed, angry, neglected
Threats of abandonment	Anxious, inhibited, self-blame
Unpredictable/chaotic planning	Anxious, inhibited, neglected
Irritability/over-reactions	Inhibited, physically abused
Distorted expressions of reality	Anxious, confused
Strange behaviour/beliefs	Embroided in behaviour, shame, perplexed, physically abused
Dependency	Caretaker role
Pessimism/blames self	Caretaker role, depressed, low self-esteem
Blames child	Emotionally abused, physically abused, guilt
Unsuccessful limit-setting	Behaviour problem
Marital discord and hostility	Behaviour problem, anxiety, shame
Social deterioration	Neglect, shame

Source: Ed. Reder. P, McClure. M, & Jolly. A (2000) *Family Matters: Interfaces Between Child and Adult Mental Health*. Routledge

Part 4: Specific/additional guidance: substance misuse

4.1 DEFINITION

4.1.1 When referring to substance misuse this guidance will apply to the misuse of alcohol as well as 'problem drug use', defined by the [Advisory Council on the Misuse of Drugs \(ACMD\)](#) as drug use which has:

“serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for uses and those around them.”

4.1.2 'Substance' is used to refer to any psychotropic substance (capable of affecting the mind – changing the way we feel, think or behave) including:

- alcohol
- drugs sold as 'legal highs'/'new or novel psychoactive substances'
- illegal drugs
- illicit use of prescription drugs
- over-the-counter and prescribed medicines that are used for recreational rather than medical purposes
- some plants and fungi (magic mushrooms, cannabis plant)
- cannabis resin
- tobacco
- volatile substances such as solvents (gases, lighter and other fuel).

4.1.3 It is important that all workers should be aware that the term 'substance misuse' covers a range of usage, from minor recreational through to more serious use and physical addiction. In common usage then, not all 'substance misuse' by parents leads to risk of significant harm to their children but may be indicative of potential risk. All cases should be assessed on their individual circumstances.

4.1.4 Substance use/misuse by parents/carers does not, on its own, automatically mean that children are at risk of abuse or neglect, but workers must recognise that children of problematic substance users are a high-risk group. Furthermore, adults who misuse substances may be faced with multiple problems, including homelessness, accommodation or financial difficulties, difficult or damaging relationships, lack of effective social and support systems, issues relating to criminal activities and poor physical and/or mental health.

Parents or carers who experience domestic abuse may use substances as a coping mechanism. Substance misuse may cause or exacerbate abuse within a relationship. Assessment of the impact of these stresses on the child is as important as the substance misuse. It reinforces the need to see substance misuse by parents/carers in the context of family life and functioning, and not purely as an indicator or predictor of child abuse and neglect.

4.2 GUIDANCE

- 4.2.1 This protocol is written in line with the government's [Drug Strategy 2010 - Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life](#), the National Treatment Agency's (NTA) [Models of Care for treatment of adult drug misusers](#), Department of Children, Schools and Families [Think Family Toolkit](#) and Department of Health's [Models of Care for Alcohol Misusers \(MoCAM\)](#), copies of which should be available to all practitioners in all agencies.
- 4.2.2 Hidden Harm is defined by the ACMD as "Parental problem drug use and its actual and potential effects on children" (ACMD, 2003). For the purpose of this guidance the term includes the misuse of all drugs specifically including alcohol.
- 4.2.3 In response to concerns around the children of drug misusing parents, the ACMD produced a report [Hidden Harm](#) in June 2003, outlining a series of 48 recommendations. From this inquiry, 6 key messages emerged:
- (1) We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user
 - (2) Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood
 - (3) Reducing the harm to children from parental problem drug use should become a major objective of policy and practice
 - (4) Effective treatment for the parent can have major benefits for the child
 - (5) By working together, services can take many practical steps to protect and improve the health and well-being of affected children
 - (6) The number of affected children is only likely to decrease when the number of problem drug users decreases

4.3 IMPLICATIONS FOR AND IMPACT ON PARENTING

- 4.3.1 More than 2.6 million children in the UK live with hazardous drinkers and 705,000 live with a dependent drinker (see glossary for definition) [Munro Review of Child Protection: The Child's Journey](#) . 42% of the 139 cases reviewed in the [New learning from serious case reviews: a 2-year report for 2009 to 2011 - Publications](#) featured parental substance misuse, of which 29% used drugs and 27% alcohol. Many of these cases were not known to Children's Social Care at the time.

- 4.3.2 [The National Psychiatric Morbidity Survey 2007](#) suggested that “around 79,000 babies under one in England were living with a parent who was classified as a ‘harmful’ or ‘hazardous’ drinker. Around 43,000 babies under one in England were living with a parent who had used an illegal drug in the past year.” [All Babies Count: Spotlight on drugs and alcohol, NSPCC, 2013](#)
- 4.3.3 Not all parents with drug problems cause harm to their children, but substance misuse can reduce their ability to provide practical and emotional care. It can have serious consequences for children, including neglect, educational problems, emotional difficulties, abuse, and the possibility of becoming drug and alcohol misusers themselves. It can also cause young people to become carers of addicted parents.
- 4.3.4 Substance misuse is rarely the sole cause of family difficulties. It is usually part of a complex web of coexisting problems that include poverty, social exclusion, poor mental health and unemployment, which can’t easily be disentangled from the substance misuse.
- 4.3.5 Having children may lead some parents to enter treatment and stabilise their lives, but in other cases their children may be at risk of neglect or serious harm or take on inappropriate caring roles. Key messages from [Parents with Drug Problems: How Treatment Helps Families \(NTA 2012\)](#) are:
- Parents with drug problems present real risks to their children. But drug treatment helps them to overcome their addiction and look after their children better
 - 105,780 of the people receiving drug treatment during 2011-12 (just over 50% of everybody in treatment) were either parents or lived with children
 - 40,852 were parents living with their own children and 25,341 were living with children not their own -, 1/3 of those in treatment; 39,587 were parents who were not living with their children
 - Parents who live with their own children have fewer drug-related issues than others in treatment. They are also more likely to complete their treatment successfully
 - Early intervention and joint working can maximise the positive impact treatment and support services have on parents with drug problems.
- 4.3.6 The following situations relating to a child or children should raise suspicion and will need further investigation/referral:
- abnormal or delusional thinking about a child
 - persistent negative views expressed about a child
 - hostility, irritability and criticism of a child
 - inconsistent and/or inappropriate expectations of a child
 - emotional detachment from child
 - lack of awareness of child’s needs that might require attention e.g. illness
 - sleeping with a baby or young child, due to the risk of overlaying causing death of the baby/child

- keeping a child at home to provide care (see young carer section 2.4)
- family income used for drug/alcohol purchase rather than basic essentials and exposed to fire risk
- child's safety compromised by drugs, alcohol and paraphernalia not safely stored in the home
- child exposed to criminal activity connected to substance misuse
- child exposed to contact with other substance misusing adults who may pose risks in or outside the home
- domestic abuse (see domestic abuse section 2.7.2)
- disruption to relationships with the extended family, reducing the protective factor for children
- sofa surfing with children, or in homes where children live

4.4 PREGNANT WOMEN WHO MISUSE DRUGS AND/OR ALCOHOL

4.4.1 These guidelines are intended to ensure a clear and consistent policy for those working with pregnant women who use substances, with a view to encouraging their co-operation with the relevant agencies. The overall objective is to ensure the physical well-being of both the mother and baby, and enable the baby to be safely discharged from the hospital to the care of the mother, wherever possible.

The riskiest time for drinking in pregnancy is around conception and during the first trimester when the baby's central nervous system is developing. Addressing the issues early in the pregnancy will give greater opportunity for attendance at antenatal appointments, engagement with substance misuse services and modification of lifestyle. Late booking and poor attendance for antenatal care are known to be associated with poor outcomes and therefore it is important that measures are put in place to encourage women to attend antenatal care on a regular basis. [NICE Clinical Guideline 110: Pregnancy and Complex Social Factors, September 2010](#)

Also see Maternity Services and Children's Social Care Joint Working Protocol to Safeguard Unborn Babies 2014 4LSCB

4.4.2 Substance misuse is often associated with poverty and other social problems, therefore pregnant women may be in poor general health, as well as having health problems related to drug use. As a general principle, substance misuse during pregnancy increases the risk of:

- having a premature baby
- having a baby with a low birth weight
- the newborn suffering symptoms of withdrawal from drugs used by the mother and requiring medication or other treatment
- the death of the baby before or shortly after birth
- an irritable and less responsive baby

- the newborn acquiring HIV, hepatitis C and/or hepatitis B infection
- sudden infant death syndrome (SIDS)
- physical and neurological damage to the baby, particularly if violence accompanies parental use of drugs or alcohol
- the baby suffering from foetal alcohol spectrum disorder (FASD) or foetal alcohol syndrome (FAS) when the mother drinks excessively

References:

- [The management of heroin misuse in pregnancy; time for a rethink? \[Arch Dis Child Fetal Neonatal Ed. 2011\]](#)
- [Obstetrics, Gynaecology & Reproductive Medicine Vol 20, Issue 9, Pages 278-283](#)
- [Substance misuse in pregnancy: a resource pack for professionals in Lothian, March 2010](#)

4.4.3 Mothers who are substance misusers should be encouraged to breastfeed in the same way as other mothers, including in the case of breastfeeding with hepatitis C and/or hepatitis B infection. In the case of mothers who are HIV positive, the view in the UK is that there are safe alternatives and women should be discouraged from breastfeeding; however the Children’s HIV Association guidance is that if an HIV positive mother insists on breastfeeding this should not be pursued as a child protection issue.

4.4.4 Drug withdrawal symptoms at birth referred to as ‘neonatal abstinence syndrome’ (NAS) can occur in infants born to mothers dependent on certain drugs. They may make the baby more difficult to care for in the postnatal period. These babies may be nursed with their mothers on the postnatal ward unless they require treatment.

4.4.5 The pregnant substance user is likely to feel guilty about the harm she may be causing to the baby and fearful of the judgment of others.

As soon as any agency comes into contact with a pregnant woman who is misusing substances, they should inform maternity services of their involvement, highlighting any concerns and offer reassurance to the pregnant woman that the baby will not automatically be removed or be made subject to a Child Protection Plan because of her substance misuse.

Some pregnant drug users do not come antenatal care until late pregnancy, fearing judgmental attitudes, Children’s Social Care involvement, conflict with partners or having to give up drug use.

Appendix 4: Summary of Potential Impact of Parental Drug Misuse
(taken from Hedy Cleaver. The Child's World, Assessing Children in Need, Reader DH (2000))

Age (yrs)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 - 2	Substance misuse during pregnancy may result in symptoms of withdrawal. Missed medical check-ups and immunisations. Unsuitable clothing, very poor hygiene.	Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglectful behaviour.	Care of children by different strangers at different times can lead to insecure attachments.	A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses and emotional insecurity in the child.
3 - 4	Children may be placed in physical danger by excessive parental drug misuse, <i>and by the presence of drugs in the home.</i> Children's physical needs may be neglected.	Lack of stimulation. Nursery or pre-school attendance may be irregular.	Children may take on responsibilities beyond their years because of parental incapacity.	Children may be at risk because they are unable to tell anyone of their distress.
5-9	School medicals and dental appointments missed. Psychosomatic symptoms e.g. sleep problems, bed-wetting.	Academic attainments may be negatively affected and children's behaviour in school may become problematic.	Children may develop poor self-esteem and may blame themselves for their parents' problems. Because they feel shame and embarrassment over their parents' behaviour, children may curtail friendships and social interactions.	Conduct disorders with boys e.g. hyperactivity, inattention. Depression and anxiety in girls. Children may be in denial of their own needs and feelings.
10-14	Little or no support during puberty because of parental emotional withdrawal. Early experimentation with substances more likely.	Continued poor academic performance due to caring for siblings or parents. Higher risk of school exclusion.	Restricted friendships. Poor self image and low self-esteem.	Children are at increased risk of emotional disturbance and conduct disorders, including bullying. They are also at risk of becoming drug users themselves.
15+	Increased risk of problem substance misuse. Risk of pregnancy, STIs and failed relationships.	Poor life chances due to poor school attainment or exclusion because of behavioural problems.	Lack of appropriate role models.	Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to crime.

Appendix 5: Summary of Potential Impact of Parental Alcohol Misuse

Age (yrs)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 - 2	Health risks to children include direct physical harm, including risk of serious injury or death by overlaying parents failing to ensure that the environment is safe and harm caused by impaired physical concentration, can lead to problems completing breastfeeding or nappy changing.	Possible delay in cognitive development due to lack of appropriate and consistent stimulation.	Attachments to parents may be problematic or insecure because of inconsistent and chaotic behaviour and emotional withdrawal. Children can feel loss and abandonment if drinking behaviour is placed above child's needs.	Infants may have unsuitable clothing and poor hygiene. Indifference and despair that can accompany problem drinking can mean parents do not respond to or reassure their child in appropriate and positive manner – may lead child to believe they are unloved and unlovable.
3 - 4	When a parent is intoxicated the ability to care for children can decline and children can be at risk from both physical harm and neglect. Children may be left home alone or with unsuitable carers if parents place their drinking behaviour above child's needs.	Child may have cognitive deficit due to insufficient emotional stimulation and interaction. Nursery or pre-school attendance may be irregular since problem drinking often results in parents being disorganised or inactive.	Children commonly blame themselves for family's problems and attempt to put things right in vain and attempt to make their environment better able to support them.	Children may be more at risk of emotional disturbance as they cannot easily articulate emotions. The level of this disturbance may be missed as child's behaviour does not always reflect their mental state.
5 - 9	Children may experience head and stomach aches, allergies, sleeping problems and bed-wetting.	Academic performance may be negatively affected with school attendance, punctuality, preparation and concentration also potentially affected. In contrast, some children may immerse themselves in their studies and attain well.	Children may suffer from low self-esteem and feel that they are not in control of events in their life. They may find it harder to see themselves as an individual separate to the family problems.	Girls may internalise the depression, fear, anxiety and stress caused by their parent's inconsistent and chaotic behaviour, by withdrawing into make-believe. Boys may externalise the distress, resulting in conduct problems, hyperactivity and lack of concentration.

Age (yrs)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
10 – 14	Children may receive no support through puberty because of parental emotional withdrawal. They may have difficulty in developing healthy and balanced attitudes to alcohol as a result of parental alcohol use – experimentation with alcohol and other drugs may be more likely.	Academic performance may be negatively affected due to children's concern about parental problem drinking, which can lead to children staying at home to care for family.	If parents' lives revolve around drinking, children may develop low self-esteem and blame themselves for the drinking. If income is directed primarily at parents' drinking, children may find it hard to maintain an acceptable appearance, causing them to be highly self-conscious, and may lose friendships as a result.	Children may externalise the distress caused by parental drinking problems, resulting in conduct problems. These ways of externalising/internalising difficult feelings can lead to children being labelled or identified as 'the problem' by their families and others.
15+	Can lead teenagers to drinking extremes, either mirroring their parents' problem drinking or abstaining. Risk of pregnancy, STIs and failed relationships are higher if parents, who may be emotionally withdrawn, do not discuss these issues with teenagers.	Caring responsibilities can impact negatively on a teenager's education and their future employability. If excluded from school, parents may be incapable of getting children back into school or supporting their continued learning.	If parents' behaviour is inconsistent and chaotic, children may have low self-esteem, feel rejected, isolated, unable to control events in their life.	Teenagers may show extremes of behaviour that are beyond parental control. Adolescents may resort to stealing when income is spent on parental drinking, and this criminal and anti-social behaviour may bring them into contact with the Criminal Justice system.

Appendix 6: Summary of Protective Factors in Relation to Parental Substance Misuse

Age (yrs)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 5	<p>Good regular antenatal care.</p> <p>Support for the expectant mother of at least one caring adult.</p> <p>Medicines and illicit drugs are safely stored.</p> <p>Sufficient income and good physical living standards.</p>	<p>Regular supportive help from primary health care team and Children & Families.</p>	<p>The presence of a caring adult who responds appropriately to the child's needs.</p>	<p>The presence of a caring adult who responds appropriately to the child's needs.</p>
5 – 9	<p>Attendance at school medicals.</p>	<p>Regular attendance at school.</p> <p>Sympathetic, empathetic and vigilant teachers.</p>	<p>A supportive older sibling. Children who have at least one mutual friend have higher self-worth and are less lonely than those without. Social networks outside the family, especially with a sympathetic adult of the same sex. Belonging to organised out-of-school activities.</p> <p>Being taught different ways of coping and knowing what to do when parents are incapacitated.</p>	<p>The presence of an alternative, consistent, caring adult who responds appropriately to the child's cognitive and emotional needs.</p>
10-15+	<p>Factual information about puberty, sex and contraception.</p>	<p>Regular school attendance.</p> <p>Sympathetic, empathetic and vigilant teachers. A champion who acts vigorously on behalf of the child. For those no longer in school, a job.</p>	<p>A mentor or trusted adult with whom the child can discuss sensitive issues.</p> <p>Practical and domestic help.</p>	<p>A mutual friend. Unstigmatised support of relevant professionals.</p> <p>The ability to separate themselves either psychologically or physically from stressful family situations.</p>

Part 5: Specific/additional guidance: learning disability

5.1 DEFINITION

5.1.1 The British Psychological Society defines learning disability as assessed impairments of both intellectual and adaptive/social functioning which have been acquired before adulthood. There are a number of syndromes that can cause individuals to have a learning disability. Some people with a learning disability also have other physical and emotional conditions and may receive more than one diagnosis. This could have an impact on the kind of support they and their families require.

5.1.2 [Public Health England - Improving Health and Lives: Learning disability Observatory](#) estimates that there were 905,000 adults with a learning disability in England in 2011, of whom 21% were known to Learning Disability Services.

Estimates of the numbers of adults with learning disabilities who are parents vary widely from 23,000 to 250,000.

5.2 GUIDANCE

5.2.1 The DH published [Valuing People, 2001](#) to help people promote the rights of people with learning disabilities. Since then there have been a number of initiatives and guidance documents aimed at supporting people with learning disabilities. DH [Good practice Guidance on Working with Parents with a Learning Disability, June 2007](#) says people with learning disabilities have the right to be supported in their parenting role, just as their children have the right to live in a safe and supportive environment.

5.3 IMPLICATIONS FOR AND IMPACT ON PARENTING

5.3.1 Researchers suggest that parental ability is not related to IQ except when it falls below the range of 55-60. It is rare for mothers with a learning disability to harm their children; the children are more likely to be at risk of unintended neglect or harm from a person known to the mother. ([Good Practice Guidance for Clinical Psychologists when Assessing Parents with Learning Disabilities](#) ed. Dr Sandra Baum, Dr Gemma Gray & Dr Sheila Stevens, March 2011)
[http://dcp.bps.org.uk/dcp/dcp-publications/good-practice-guidelines/good-practice-guidance-for-clinical-psychologists-when-assessing-parents-with-learning-disabilities\\$.cfm](http://dcp.bps.org.uk/dcp/dcp-publications/good-practice-guidelines/good-practice-guidance-for-clinical-psychologists-when-assessing-parents-with-learning-disabilities$.cfm)

- 5.3.2 Parents with learning disabilities frequently face challenges in their home environment; they may live with their own parents or family members which reduces any personal control they have over the domestic environment or the parenting of their children, or they may be quite isolated from social support.
- 5.3.3 Parents with learning disabilities face a high risk (50%) of having their children removed into care, usually as a result of concerns for the children's well-being and/or an absence of appropriate financial, practical and social support to perform their parenting role effectively. ([Booth et al \(2005\) Care proceedings and parents with learning difficulties: comparative prevalence and outcomes in an English and Australian court sample. *Child and Family Social Work*, 10, 353-360](#))
- 5.3.4 Parents will need support and reasonable adjustments to develop the understanding, resources, skills and experience to meet the needs of their children. This support should be tailored to the learning style of the individuals and is particularly important when parents experience additional stressors such as having a disabled child, domestic isolation, poor housing, poverty and a history of growing up in care or poor parenting of themselves. It is these additional stressors when combined with a learning disability that are most likely to lead to concerns about the care and safety of a child rather than the intellectual capacity of the parent.
- 5.3.5 Research evidence highlights the need for independent advocacy when parents with learning disabilities are at risk. "Parents with learning disabilities also need to have access to the same level of information and advice available for all parents." [Valuing People Now Summary Report: March 2009 - September 2010](#).
- 5.3.6 The majority of children born to parents with learning difficulties do not have learning difficulties themselves. [Finding the right support? A review of issues and positive practice in supporting parents with learning difficulties and their children \(Beth Tarleton, Linda Ward & Joyce Howarth, 2006\), the Baring Foundation](#)
- 5.3.7 Teenagers may be more able than their parents, if the parent(s) has a learning disability, and are likely to take on the parenting role, becoming responsible for housework, cooking, correspondence, dealing with authority figures, and the general care of their parents and younger siblings. (see young carers, section 2.4)
- 5.3.8 Many parents with learning disabilities do not meet eligibility criteria for Adult Services. **However it is important to remember that under the Fair Access to Care criteria any safeguarding (children or adults) issues escalate eligibility status to critical or substantial.**
- 5.3.9 Consistent support, appropriate communication and multi-agency working, including those with knowledge of working with people with learning disabilities, appear to offer the best chance of people with a learning disability being 'good enough' parents. If you have any concerns about the children of adults with learning disability, you should contact your local Adult Services learning disability team to establish if the adult is known to services or make a referral through the normal routes. (see back page for contact details).

5.4 PRENATAL AND POSTNATAL PERIOD

- 5.4.1 Specific concerns apply to the pre and postnatal periods. It is vital that there is joint working between GPs, Midwifery, Health Visiting and, if involved, specialist Learning Disability Services. It is essential to identify needs, assess and, if necessary, prepare safeguarding plans for both mother and child.
- 5.4.2 Parents with a learning disability will require additional support before the baby is born to understand what is happening, to participate effectively in antenatal classes and at check-ups. Careful consideration will be required to ensure communication methods are appropriate to the needs of the person e.g. repeated information giving, easy read or visual documents.
- 5.4.3 Parental learning disability may impact on the unborn child because it affects parents in their decision-making and preparation for the birth. The quality of the woman's antenatal care is often jeopardised by late presentation and poor attendance. When women with learning disabilities do attend antenatal care they may experience difficulty in understanding and putting into practice the information and advice they receive.
- 5.4.4 Parents with a learning disability may struggle to adjust to developmental changes in the child, e.g. eating solid food, walking and may need additional support at these times.

GLOSSARY

ACMD	Advisory Council on the Misuse of Drugs	An independent expert body that advises government on drug related issues in the UK.
CAF	Common Assessment Framework	The CAF is a standardised approach to conducting assessments of children's additional needs and deciding how these should be met; used by practitioners across the children's workforce in England. Some areas may use an Early Help Assessment and Plan in place of a CAF (see Early Help Plan)
CAMHS	Child and Adolescent Mental Health Services	NHS services providing help and treatment for children and young people and their families with emotional, behavioural and mental health difficulties.
	Child Protection Conference	A confidential meeting between parents, social services child protection workers and other professionals to discuss the welfare of a child(ren), after an enquiry has shown that a child(ren) is at risk of abuse or neglect, and to agree what needs to be done to reduce this risk.
	Child Protection Plan	Plan to detail risks to a child; to clarify what needs to change to reduce or eliminate the risk; tasks that parents and professionals need to undertake with timescales, targets and monitoring arrangements.
	Children's Social Care or Children's Services	Local Authority Department with wide statutory responsibilities for children, including safeguarding. Any other reference to 'services for children' relates to all statutory and non-statutory services.
	Core Group	A group of identified professionals who have a key role to play in the Child Protection Plan, along with, where appropriate, the parents and child. Together the Core Group has responsibility for developing, implementing and reviewing the Child Protection Plan ensuring the welfare of the child remains paramount.
CPA	Care Programme Approach	Planning process for people who use secondary mental health services. May also be used in Substance Misuse Services and CAMHS.
Detox	Detoxification	Treatment for addiction to drugs or alcohol intended to remove the physiological effects of the addictive substances. Can be undertaken as an in-patient or in the community.
DH	Department of Health	Government department with remit to improve the health and well-being of people in England.

DA	Domestic abuse	Domestic abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.
	Early Help Plan	Plan to provide help at an early stage to prevent escalation of need. May be used as an alternative to a CAF (see CAF)
EIP	Early Intervention in Psychosis Team	Secondary mental health specialist service for people aged 14-35 offering help, assessment, treatment and support to young people and their families in the early stages of a psychotic illness.
FAC	Fair Access to Care	Eligibility criteria that adult social care departments use to determine whether a person is entitled to receive services they provide or commission. DH Guidance 2002.
	Filicide	The deliberate act of a parent killing their own son or daughter.
	Harmful drinking	Defined as when a person drinks over the recommended weekly amount (21 units for men and 14 units for women) and has experienced health problems directly related to alcohol.
	Hazardous drinking	Defined as when a person drinks over the recommended weekly limit. Can include binge drinking within weekly limits. Not yet experiencing related health problems.
	Infanticide	Homicide of an infant by a mother.
	Lead Professional	When a child or young person with multiple needs requires support from more than one practitioner, the lead professional acts as a single point of contact that the child or young person and their family can trust and who is able to support them in making choices and navigating their way through the system, ensuring they get appropriate interventions when needed, which are well planned, regularly reviewed and effectively delivered.
	Legal highs (also known as new or Novel Psychoactive Substances)	Intoxicating drugs which are not prohibited.

LSCB	Local Safeguarding Children Board	Key statutory mechanism within each Local Authority for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children. There is one in Hampshire, Isle of Wight, Portsmouth and Southampton.
MAPPA	Multi-Agency Public Protection Arrangements	Statutory arrangements supporting the assessment and management of the most serious sexual and violent offenders in the community.
MARAC	Multi-Agency Risk Assessment Conference	Process combining risk assessment and a multi-agency approach to help very high risk victims of domestic abuse.
NICE	National Institute for Health and Care Excellence	Non Departmental Public Body responsible for developing guidance and quality standards in health and social care.
NTA	National Treatment Agency	Established in 2001 as an NHS Special Health Authority to improve the availability, capacity and effectiveness of drug treatment in England. From April 1 st 2013, it became part of Public Health England (an Executive Agency of the DH)
Ofsted	Office for Standards in Education, Children's Services and Skills	Regulatory and inspection office with aim of achieving excellence in the care of children and young people, and in education and skills for learners of all ages.
	Perinatal	During pregnancy and for twelve months after birth.
	Practitioners	Any local paid or volunteer practitioners who might come into contact with parents with complex needs or their children.
Rehab	Rehabilitation	Frequently residential provision following detox to enable people to address non-treatment specific issues relating to their drug or alcohol problems, usually funded by Adult Services. See detox above.
SCR	Serious Case Review	Local enquiry into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. Carried out by LSCBs, they are currently evaluated by Ofsted.
STI	Sexually Transmitted Infection	Diseases passed on through intimate sexual contact; common STIs in the UK include chlamydia, genital warts and gonorrhoea.

TAC	Team around the child	A way of working with children and young people who, through the use of the CAF or initial assessment, have been identified as having unmet needs and require support from more than one agency/service to meet these needs.
	Threshold document	Documents that LSCBs are required by WT 2013 to publish showing: <ul style="list-style-type: none"> ■ the process for the early help assessment and the type and level of early help services to be provided ■ the criteria, including the level of need, for when a case should be referred to Children's Social Care for assessment and statutory services under S17, S47, S31 and S20 of the Children Act 1989. (see WT 2013)
	Universal services	Services available to the general public e.g. GPs, health and educational services.
WT 2013	Working Together to Safeguard Children, Department for Education, 2013	Department of Education statutory guide which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and how practitioners should conduct the assessment of children.

4LSCB

Local Safeguarding
Children Boards

www.4lscb.org.uk

For **Children's Social Care** phone:

	Hampshire	Southampton	Portsmouth	Isle of Wight
Office hours	0845 603 5620	023 8083 3336	023 9283 9111	0845 650 0097
Other times	0845 600 4555	023 8023 3344	0845 600 4555	01983 821105

For **Adult Services** phone:

	Hampshire	Southampton	Portsmouth	Isle of Wight
Office hours	0845 603 5630	023 8083 3003	023 9268 0810	01983 814980
Other times	0845 600 4555	023 8023 3344	0845 600 4555	01983 821105

Phone numbers correct as at January 2014.

