Index No:

					7

Joint Working Protocol

Approved
FINAL
16 July 2004

Author/s

Name: Pauline Lambert
With integrated adult services
and ACPC

Title: Nurse Consultant Child Protection

Responsible Lead Clinician/Deputy

Name: Pauline Lambert

Title: Nurse Consultant Child Protection

Ratified by: …… Elizabeth Green …… **Medical Director**

Date: ……10 August 2004……..

Ratified by: …… SK Healey. …… **Nurse Executive**

Date: ……20 July 2004……..

Review Date: 1 April 2006

Reviewed by: ……

Title: ……

1. Key Words

Joint working, Mental Health, Learning Disabilities, Substance Misuse

2. Associated Documents

This document is to be read in conjunction with:

2.1 ACPC CP Procedures

8. Implementation Plan

To become integral aspect of ACPC CP Procedures.

JOINT WORKING PROTOCOL

Children & Families Services and Adult Services Brighton and Hove

March 2004

Promoting the well-being of children and keeping them safe should be achieved, wherever possible, by providing support for parents in bringing up their children and by ensuring that children do not take on excessive or inappropriate caring roles in their family.

Balancing the needs of both children and adults in these families can pose difficult dilemmas. A great deal of collaboration has occurred between services and agencies to achieve production of this protocol. It has been produced to reinforce working together through joint assessment, care-planning, management of risk, monitoring and case reviews.

A Universal protocol has been produced that should be applicable to all agency settings and to all parents who make contact with services. Supplementary information pertinent to different groups or services are included as appendices.

This protocol is a necessary part of the inter-agency repertoire and is provided to achieve clear, consistent and competent practice. However it does not ensure that families will get reliable help and is not a substitute for expert, confident, well supported practitioners in adult and children services who are able to reflect on and critically appraise an individual situation and make sound, knowledge based decisions alongside service users.

This protocol will be reviewed on a regular basis. Thanks are extended to everyone who provided feedback during development of the protocol. Not all of the suggestions could be incorporated in to this version some will be taken forward and incorporated into future versions. Particular thanks are extended to clinicians from Learning Disabilities, Adult Mental Health, Substance Misuse, Out of Hours Services and Children and Family Services who committed time and energy into its production.

Acknowledgement also needs to be extended to East London and The City Mental Health Trust and Hampshire, Portsmouth and Southampton Social Services and Health Trusts for sharing their protocols with us.

CHILDREN & FAMILIES SERVICES AND ADULT SERVICES JOINT WORKING PROTOCOL

1. INTRODUCTION

1.1 Background 4
1.2 Scope 4
1.3 Aims 5

2. GENERAL PRINCIPLES

2.1 Children in need 6
2.2 Working in partnership 6
2.3 Early consultation 6
2.4 Prevention 7
2.5 Joint Working 7
2.6 Staff development 7

3. PRACTICE GUIDELINES

3.1 Responsibility 8
3.2 Recording and information sharing 9
3.3 Cross-checks 10
3.4 Immediate risk 10
3.5 Significant harm 10
3.6 Review and ongoing work 11

Checklist flowchart for Adult workers 12
Checklist flowchart for Children and Family Workers 13

Appendices:

A. Adult Mental Health
- In- Patients
- CMHT
- Young Carers
- Out of Hours

B. Learning Disabilities

C. Substance Misuse

D. Assessment of parenting capacity guidance

E. SDHT & CF & S structure charts

1.1	Background	Cross reference
1.1.1	Community Services to families have undergone a number of organisational changes. The Children and Families Directorate has been created in South Downs Health NHS Trust. Social work and education services are located in the Brighton & Hove City Council Children Families and Schools Directorate. There will be continuing developments.	*See appendix E for SDHT & B&H City Council Structure Charts*
1.1.2	Adult services are located within a number of directorates in South Downs Health NHS Trust and Brighton and Hove City Council. There are now a number of integrated and jointly managed adult health and social work teams, including Adult Mental Health services, Learning Disabilities services and Out of Hours services.	
1.1.3	Within Brighton and Hove City some services are also provided by voluntary and/or private organisations. Each voluntary/private provision is expected to have a child protection policy that has been ratified by the ACPC and to follow ACPC CP Procedures or have procedures made explicit within their policy.	
1.1.4	Organisational changes have resulted in, and are likely to continue to cause difficulties for individual workers in negotiating plans for children and adults across organisational boundaries. This situation is especially likely to occur where there are children of parents with social, medical or developmental problems causing impairment of physical or mental functioning.	

1.2	Scope	Cross reference
1.2.1	This protocol is intended to assist the following groups: i) All staff working with children and families in social work services and health services ii) Any staff of any discipline working in community adult social work and health services iii)	
1.2.2.	It is recognised that our organisational structures	

	are constantly changing and this protocol will need revision and amendment as new challenges emerge in delivering services. This protocol has been produced to ensure appropriate services are in place for children identified as 'in need' or 'at risk' as a result of the impact of parents behaviour.	

1.3	**Aims**	**Cross reference**
1.3.1	To improve and develop our services to families in which there are dependent children where there are parents who have social, mental or developmental problems causing impairment of physical or mental functioning (temporary or permanent).	
1.3.2	To establish good co-operation and communication between children's services and adult health and social care services in order to achieve improved access to resources and collaborative decision making. Avoiding where possible, multiple assessments by different workers.	
1.3.3.	To ensure safe management of risk while providing a responsive service to families which is sensitive to their special needs to facilitate future preventative and support work.	
1.3.4.	To support interagency and interdisciplinary training and education	

2.1	**Children in need**	**Cross reference**
2.1.1	All children in families where there are problems as defined in paragraph 1.3.1 meet the criteria for children in need. They are entitled to an assessment of their needs under the Children Act 1989 and, if providing care, under the Carers (Recognition and Services) Act 1995.	**Framework for the Assessment of Children in Need and their families, DoH 2000.* **B&H Family Support Strategy 2003* **Carers & Disabled Children Act 2000*

2.2	**Working in partnership**	**Cross reference**
2.2.1	Any areas of identified concern should to be discussed fully with the parents, who may or may not share the concerns. The need for involvement of Duty and Assessment Team/Hospital SW team/ Long Term Teams should be explained whilst taking account of the parent's right to confidentiality about his/her illness/disability/impairment. Equally Children & Family services may need to consult with specialist services depending on concerns they have identified.	**Working together to safeguard children DoH 1999* ** Refer to B&H ACPC CP Procedures*
2.2.2	Where English is not the parent or child's first language. Cultural issues should be taken into account when planning care. Access to appropriate interpreting services should be organised. If this does not occur decision making processes should be recorded in the records.	

2.3	**Early consultation**	**Cross Reference**
2.3.1	Each service will have their own criteria for prioritising referrals. This must not become an obstacle to co-operation at an early stage. Each service has a responsibility to consult with or advise colleagues in order to facilitate preventative work. Key information should be followed up in writing.	**Working together to safeguard children DoH 1999* *Refer to flow charts Pages 12*

		and 13

2.4	**Prevention**	**Cross reference**
2.4.1	All workers in adult health or social care teams need to be alert to children's needs and signs of neglect or significant harm. They have a responsibility to consult with colleagues in children's services.	**B&H ACPC CP Procedures* **Family Support Strategy*

2.5	**Joint working**	**Cross Reference**
2.5.1	Where the level of concern requires workers from both children's and adult services to be involved, joint planning and assessment should take place from the outset. It is the responsibility of staff to ensure this happens. Advice and support can be provided from team managers/supervisors.	

2.6	**Staff development**	**Cross Reference**
2.6.1	It is recognised that working with such complex situations requires a high level of skills and workers have a responsibility to take advantage of training which will be available for joint working at the interface of children's services and adult services. Employers also have responsibility to facilitate access to training.	**Crossing Bridges DoH* **ACPC Interagency Training B&H*
2.6.2	To identify and assess risk, good practice guidelines should be used. These are available to support staff to consider how and what information to collect and share.	*These include:* **Drugscope (SCODA)* **DV*

3.1	Responsibility	Cross Reference
3.1.1	The Children Act 1989 makes the welfare of the child paramount and this must be the first consideration for all workers. Children and Families teams have statutory responsibility for the protection of children.	
3.1.2	Where a child is 'in need' or is 'at risk' (and in need of protection) because of their parent's behaviour due to an identified concern, the parenting capacity of the carer and risk they pose to the child must be assessed. This is best brought about by joint planning of the assessment by adult and children & families staff together. Joint planning of assessments, sharing of information about risk factors, and joint working is of benefit to all, not least the family.	*See appendix D. Assessment of parenting capacity guidance.*
3.1.3	Critically important to a child's health and development is the ability of parents or caregivers to ensure that the child's developmental needs are appropriately and adequately responded to, and to adapt to his or her changing needs over time. All workers have a professional responsibility to ensure they are informed about the impact of parental behaviour on children. In family situations where there is cause for concern about what is happening to a child, it becomes important to gather information about how parenting tasks are being undertaken.	**Page 20 in Framework for the Assessment of Children in Need and their families, DoH 2000*
3.1.4	Workers should understand the implications of the Human Rights Act. Article 8 of the European Convention on Human Rights (which forms part of UK Law) recognises a right to respect for private and family life. The right is not absolute. Disclosing confidential information to protect the welfare of a child can be justified by Article 8(2) if it is necessary to prevent crime or to protect the health and welfare of a child. Workers should guard against treating some parents less favourably than others. E.g. failing to consult or inform.	**Human Rights Act 1998* **What to do if you are worried a child is being abused, DoH 2003*

3.2	**Recording and information sharing**	**Cross reference**
3.2.1	Sharing information for the purposes of safeguarding and promoting the welfare of children is essential. In many cases it is only when information from a range of sources is put together that a child can be seen to be in need or at risk. It is good practice for teams and ward staff to record names, dates of birth, GP, health visitor/ school involvement of other agencies and areas of concern for all children in families known to them. This is to aid liaison across services. If a parent is unwilling to give this information this should be noted. It is good practice to explain to families that liaison and/or information sharing will happen within and/or across agencies. This is to ensure effective care is provided and guided by a 'need to know' basis. A parent may not share the professionals' concerns in which case the requirement to pass information to other agencies needs to be explained clearly to the parent and their views noted.	**What to do if you are worried a child is being abused. DoH 2003*
3.2.2	Only in exceptional circumstances if the child's or workers immediate safety would be compromised should information be passed on without informing the parent. In this case the reasons for that decision must be clearly recorded and past on in the referral.	
3.2.3	All information passed to other agencies should be recorded on file in such a way that both what has been said and the parent's views are clear. All referrals should be followed up in writing with a copy to the parents/carers when ever possible. On occasions a separate letter to the parents using accessible language may be necessary, a copy of this letter should be sent with the referral.	

3.3	Cross-checks	Cross reference
3.3.1	It is good practice to ask children and parents about what other services they are receiving. Cross-checks where possible should be made on the computer systems to establish if children or parents are currently receiving services elsewhere in the organisation. Where adult and children's services are both involved consultation must take place between the two and parents should be advised of the value of this.	
3.3.2	If the clinician does not have access to IT systems, this information needs to be found out by other means.	

3.4	Immediate risk	Cross reference
3.4.1	a) Emergency admission to hospital for medical reason/s b) Child in need of urgent protection	
3.4.2	Where these situations involve behavioural impairment in parents and there are dependent children there must be urgent consultation and planning involving all relevant services so that the needs of both children and the adult are addressed. A joint assessment of the situation and planning should take place with the possibility of a joint visit as required.	

3.5	Significant harm	Cross reference
3.5.1	All adult services need to be alert to the possibility of significant harm to children and to signs of neglect. Particular children may be especially vulnerable: i) Children under 5 years old and new-born babies ii) Children with chronic illness iii) Children with disability iv) Children with special educational needs v) Children in a caring role – 'Young Carers' vi) Where there is domestic violence/substance misuse vii) Where there is a history of sexual abuse	*Refer to ACPC CP Procedures*

	in one of the parents viii) Children who live alone with a single vulnerable adult (especially if there are pre-school children)	
3.5.2	Where these factors may be present adult workers have a responsibility to discuss the situation with their team manager/supervisor. Where there is concern regarding neglect/significant harm they should consult with the Duty and Assessment Team indicating the need for intervention. At all stages concerns should be discussed openly with parents in a climate of partnership and an attempt to meet needs. Staff should communicate with parents in a way they understand. Adult services will make available to colleagues in children's services advice support/joint working options. This may need to happen when the behaviour of the parent/carer appears to compromise the well being of the child. Or where the parent of a child with whom they are involved is difficult to engage. The client may or may not be known to the specialist service.	

3.6	**Review and ongoing work**	**Cross Reference**
3.6.1	Where two or more workers continue to be involved over a period of time e.g. because a child is accommodated and a complex support package is in place, they will need to ensure that their work continues to be co-ordinated. They should set regular dates to meet or review the situation to ensure that there is: adequate communication, needs are not overlooked, visits are not duplicated and professionals do not become divided. At present responsibility for co-ordinating these rests with individual workers and team managers.	

Checklist for Adult Services.

Remember to work in partnership with parents – consult and inform as fully as possible.

1. Is your client a parent or carer of children under 18 years? → **YES** → Record children's names and dates of birth on file

↓ **YES**

2. Is there an urgent child protection or child 'in need' concern? → **YES** → Phone Duty and Assessment Team on 296000 for joint assessment and joint planning

↓ **NO**

3. Has the family had previous contact with children& families teams? Ask patient/service user & check IT systems → **NO** → Make a written referral to Duty and Assessment Team if the family are in need of support.

↓ **YES**

4. Is there an allocated social worker? → **YES** → Liaise and consult on a regular basis. Jointly planned work is desirable.

↓ **NO**

5. Are parents concerned about their children's welfare? → **YES** → Make a written referral to Duty and Assessment Team for 'Child in need' and family requiring support.

Use DAT referral Form

↓ **NO**

6. Are professionals concerned about the child/ren's welfare? → **YES**

Record decision making and plans

Record discussion with family members.

↓ **NO**

7. Are the following present? → **YES**
a) Children under 5
b) Children with identified special needs
c)Children with chronic disabilities

If there is evidence of neglect/violence consider making referral under CP Procedures.

8. Is there evidence of neglect? → **YES**

9. Is there history of violence? → **YES**

10. Does your client have sole carer responsibility? → **YES**

11. Does a child have caring responsibility? → YES → Refer to Young Carers Services or to Duty and Assessment Team under the Carers Act 1995.

Checklist for Children's Services.

Remember to work in partnership with parents – consult and inform as fully as possible.

URGENT CHILD PROTECTION PROCEDURES MAY APPLY AT ANY STAGE

1. Where possible ask family about the services they are receiving. Routine IT/telephone checks on all family members.

2. Is there an allocated adult worker?
   - YES → Liaison with adult services Consider whether 'Child in Need' assessment or referral needs to happen.
   - NO

3. Is a parent or other household member presenting illness/disability/impairment problem?
   - YES → Immediate contact with appropriate adult team for joint assessment and joint planning.

     Consider whether 'Child in Need' assessment or referral needs to happen
   - NO

4. Has the parent or other household member used adult services in the past? Does a parent or other household member have a history of illness/disability/impairment/substance misuse?
   - YES → Consider whether 'Child in Need' referral needs to be made to DAT.

     Liaise with GP

     Consult with appropriate adult team

     Joint assessment and planning desirable.
   - NO

5. Is the parent showing signs of being dependent on the child?
   - YES → Refer to Young Carer Services (AMH)

     Or Make 'Child in Need' referral to DAT
   - NO

'TARGETED' Health visiting or School Nursing Service

Review on regular basis and make 'child in need' referral if needed (use CF&S referral criteria)

Appendices

GUIDANCE TO STAFF REGARDING AMH IN-PATIENTS WHO ARE PARENTS.

This section provides guidance to staff for supporting children (age 0-16 years) when their parent is an in-patient in an acute psychiatric unit managed or contracted by South Downs Health NHS Trust" (Operation Instructions SDHT 2000).

SDHT have a comprehensive policy that provides detailed guidance for staff when children need to be considered as part of the care package that is provided to adults in mental health in-patient services. The welfare and safety of the child visiting their parent in the unit is paramount and the responsibility of all staff. Ward staff need to ensure they are aware of their responsibilities for the in-patient as a parent and their child.

Where possible it is important to facilitate the child's contact with their parent or other key family members. Where there are concerns regarding a child, mental health staff may ask the relevant social work team to assess whether it is in the best interests of a child to visit a named patient.

Admission to an in-patient ward

- It is the responsibility of the mental health practitioner requesting in-patient admission to record and communicate to ward staff full details of the patient's responsibilities as a carer/parent.

- On admission the following information needs to be handed over and recorded; names (first names and surnames) of children for whom the patient has primary carer responsibility and their dates of birth. If the children are under school age the named Health Visitor must be identified, if attending school the name of the school should be recorded. The admission assessment should also identify and record any current contact with Children and Families social work services. Staff should explain the purpose of gathering this information to the patient to make them aware it is to help provide supportive and well co-ordinated care to the whole family.

- Information must be recorded of the contact number of the adult assuming responsibility for the child/ren whilst their parent is in hospital *(for further guidance see check list for Adult Services in the Joint Working Protocol)*

- If a parent refuses to give any of the above information this should be recorded in their records.

- It is good practice to explore as part of the admission assessment any impact that the parents mental health may have on their parenting capacity. This should help identify any practical help or support they may need while an in-patient and on discharge. (*cross reference with 'Guidelines on assessment of parenting capacity' in Joint Working Protocol)*

Following assessment :

The mental health practitioner needs to liaise with the following services:

- Undertake a Carefirst check via the relevant Community Mental Health Team
- Notify health visitor if child is under 5 years that parent/carer has been admitted
- Notify school nurse if children of school age that parent/carer has been admitted
- Notify the GP of admission in the usual way
- Complete an AMH liaison form.

If liaising with other agencies the parent /carer needs to be informed of this. It is preferably to obtain parental consent. But if it is in the best interests of the child liaison can occur without this.

Patients Going On Leave

Before making leave arrangements the Responsible Medical Officer must ensure:

- That consideration has been given to the need for additional support or practical help for the family during the leave period from relatives or others.
- That any risks to the child have been fully explored .
- Liaison and co-ordination has occurred with all relevant services (eg GP, HV, School Nurse, SW). If needed a 'child in need' (family support) or child protection referral should be made as soon as possible after admission.
- Documented that there has been discussion with the children's temporary carer concerning the patient/parent's needs and the purpose of leave from in-patient care. This will include the degree to which the patient/parent is able to resume their physical and emotional care of any child/ren.

The primary nurse should arrange for the children's temporary carer/s to provide feedback to the clinical team concerning the effects of the leave on the family.

In-Patient care Discharge arrangements

In addition to the above under leave arrangements the following should occur as part of discharge planning:

- Prior to discharge the care co-ordinator and primary nurse must ensure that the patient's CPA Care Plan records a plan to manage any risks/ additional needs related to the welfare or care of the child/ren resulting from the patient/parent's mental health, and that relevant information has been provided to GP, health visitor, school nurse and any social worker with responsibility for a child/en welfare. Assessment at this stage must take account of the extent to which the patient is able to resume their parenting responsibilities (fully or partially). Considerations may need to be given to a home assessment. Staff should negotiate with others involved in providing care to the family who is best placed to undertake this. Joint assessment will be more comprehensive is well co-ordinated.

- Relevant carers within the family system should be invited to discharge planning meetings and informed of their entitlement to have their own needs as carers assessed.

- The patient's CPA Care plan and discharge summary must identify help that the patient/parent may need at home in resuming parental responsibilities. Roles and responsibilities of all services involved in providing care and support to the family should be discussed and agreed.

Planning contact and arranging Visits for a child/ren while their carer /parent is an in-patient

Arrangements for contact between a patient with parental responsibilities and their child/ren during their in-patient stay must be pre-arranged through the Nurse in Charge or Primary Nurse. On admission this information should be given to the patient and the child's carer.

Contact arrangements will need to take account of :

- Whether it is known that the that the hospital is accommodating a schedule 1 offender

- The environment or patient mix pose any risks to the welfare of the child

- Arrangement of visiting times that are appropriate to the age and needs of the child

- The needs of the person supervising the child during contact

- The expressed wishes of the parent who is an in-patient

- The availability /desirability of the contact visiting taking place at either the hospital or at an alternative venue

- Availability of the designated visiting room within the hospital (children's visits will not be accommodated on the wards)

For the duration of the visit the child's carer is responsible for the supervision and safety of the child whilst on SDHT premises.

Guidelines for Children and Families Teams Referring to CMHTs

Contact and Team Information

Mill View CMHTs

Neville Avenue
Hove
East Sussex
Direct Referral Line: 01273 242176
Fax No: 01273 242037
Mon – Fri 9.00am to 5.00pm

West 1 –
Dr S Yagoub
Dr S Baker

CMHT Managers:
Patrick Callaghan/
Helen O'Neil

West 2 –
Dr T Ojo/
Dr R Gimbrett

CHMT Manager:
Dave Tulley

East Brighton Community Mental Health Centre

Brighton General Hospital, Elm Grove
Brighton
East Sussex BN2 3EW
Direct Referral Line: 01273 242102
Fax No: 01273 242101
Mon – Fri 9.00am to 5.00pm

East 1
Dr R Whale/
Dr T Sales

CMHT Manager:
Fiona Blair

East 2
Dr N Farhoumand

CMHT Manager:
Mike Ong

Working Hours and Contact Details Out of Hours:

1. **CMHT's: – Monday to Friday 9.00am – 5.00pm**
2. **Out of Hours Team: 01273 295801 - 3pm to 9.30pm weekdays, 12 midday to 11pm weekends (professionals only)**
3. **Mental health helpline for clients: - 0808 8083333 7.00am – 11.00pm**
4. **Emergency Duty Team: 07699 391462 Weekdays; 5.00pm – 9.00 am , Weekends 24 Hours**

How to refer to the Community Mental Health Teams (CMHT's in Brighton & Hove

The CMHT's are integrated Social Care and Health Multi Disciplinary teams and include psychiatric doctors, CPN's, Social Workers, Occupational Therapists, Community Support workers and Administration Staff. Teams are linked to specific in patient wards.

How to make a Referral

The CMHT's are secondary mental health services and referrals are from GP's in Primary Care.

Social Care and Health professionals who have a concern about the safety or welfare of children where the parents are considered to have mental health problems, should contact the parent's GP. The GP may then make a decision to refer to the CMHT's. In some cases it maybe necessary for the childrens worker to make a joint referral with the GP or with the GP's knowledge. It is important that the client and doctor with medical care for the the patient is as fully informed as possible about the referral. If this is not possible please liaise with the CMHT Duty Worker / Manager.

The referral should provide the following information where possible to allow the service to offer advice and information or to undertake an initial assessment.

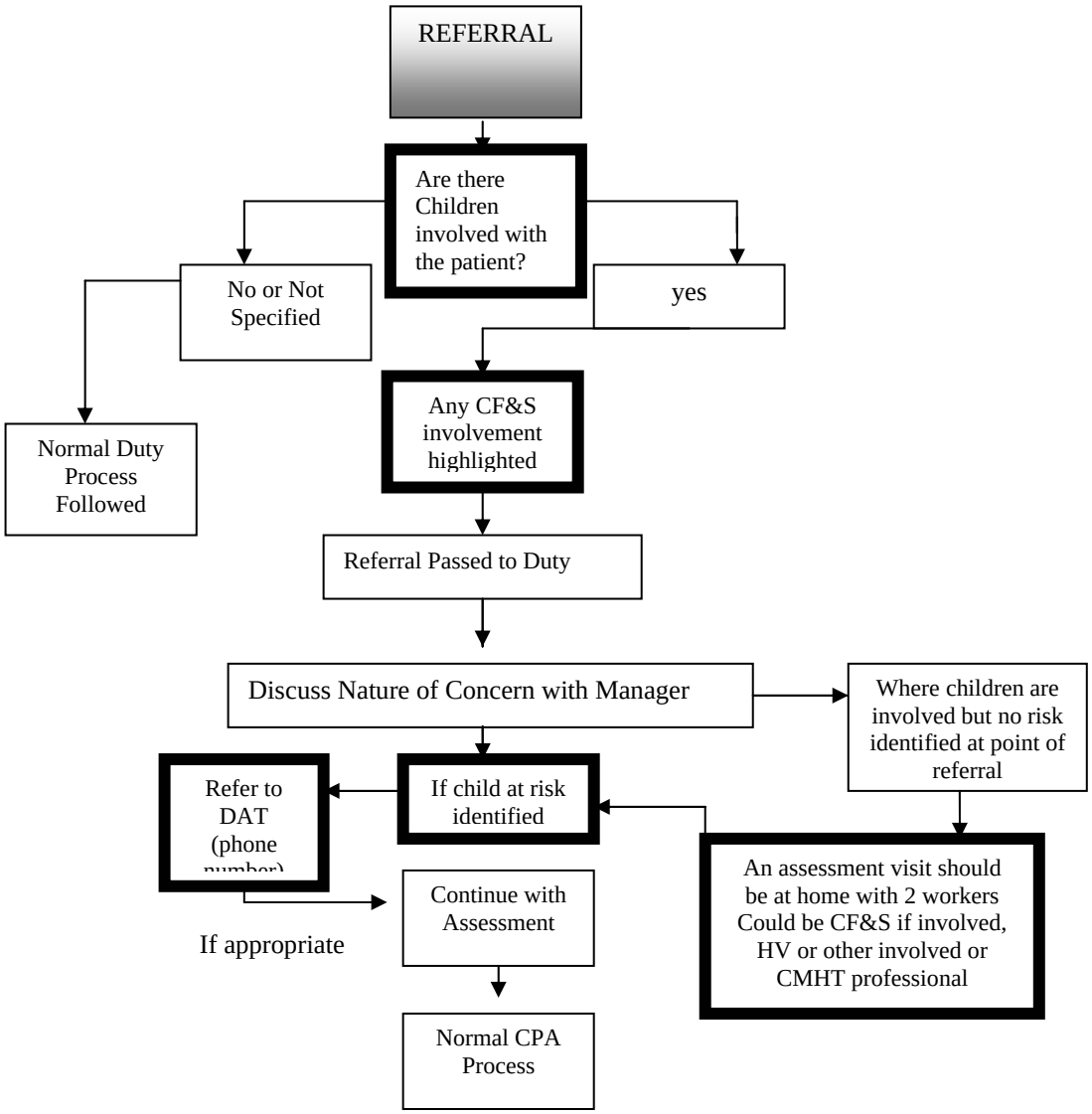
Essential Information

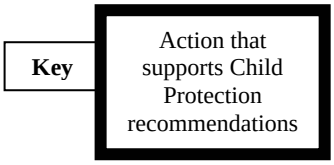
- Complete name, address and telephone number of the client and family members.
- Reasons for referral including current behaviour relating to the person's mental health problem including urgency of referral.
- How this impacts on the care of the children
- Important social factors which support or adversely affect the person's mental health
- Any known past or present involvement with mental health services – statutory, voluntary, etc.
- Any other relevant information
- What action and desired outcome is requested.

What happens next

Information will be checked to see is the client is known to the services. The referral will be discussed by the duty worker with the team manager and or the child protection 'liaison' worker to agree a response and assessment / follow up.

Process map for referrals to the CMHTs involving Children





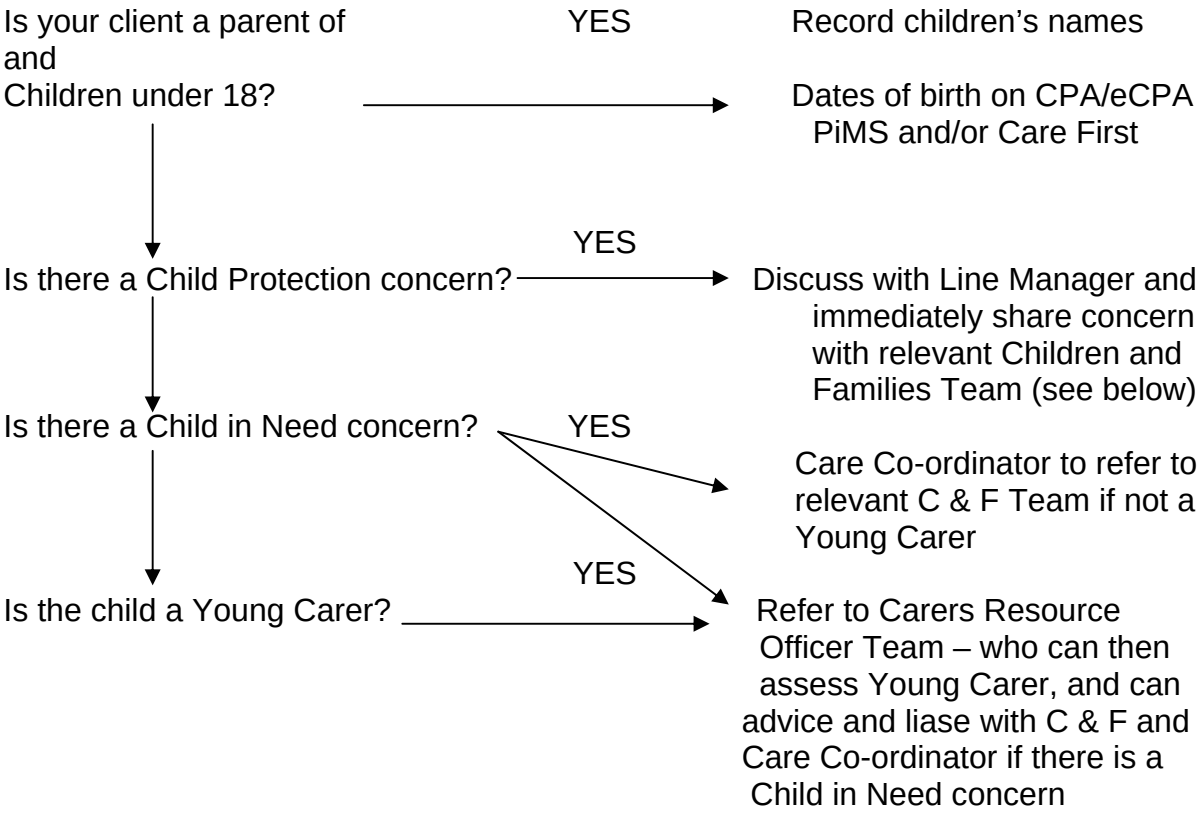
GUIDELINES FOR WORKING WITH PARENTS WITH MENTAL HEALTH PROBLEMS AND THEIR CHILDREN

These guidelines have been set up in response to the joint working protocol for Children & Families Services and Adult Services, with regard to Working Age Adult Mental Health Services in the City of Brighton and Hove. The aim of these guidelines is to provide good practice for any mental health workers in identifying, assessing and supporting the children of a mental health service user.

"All professionals working in Mental Health Services in the statutory, voluntary and independent sectors, should bear in mind the welfare of children, irrespective of whether they are primarily working with adults.They may need to fulfil their duty to assist Social Services in assessments, as well as by attending and reporting to Child Protection Conferences when necessary"
(From Department of Health Guidance *Working Together to Safeguard Children* (1999) para 3.39).

Recommendations from Case Reviews under Part 8/Chapter 8 of Working Together to Safeguard Children underline the necessity for joint working and information sharing, but also relate to the necessity for the needs of children to be considered at Care Programme Approach Planning meetings. All involved professionals should consider the potential impact of the client's mental health problems on the child as well as the potential impact of these problems on the client's ability to parent.

Flowchart for Mental Health Staff



Children in need of Protection

If a mental health worker has concerns about the safety or welfare of any children of a client, this should be discussed immediately with their line manager and shared with the relevant Children and Families Social Work Team. In the event of a need being identified for protection of a child or young carer, then the Child Protection Procedures should be followed and the Care Co-ordinator will take lead responsibility for initiating this.

If Children,Families and Schools(CF&S) services are already involved with the child then the Care Co-ordinator should discuss any Child Protection concerns with the CF&S social worker. If there has been, or is a need, for a assessment framework for a 'child in need' known to CF&S services, then either a Resource Officer for Carers (if a young carer is involved) or the Care Co-ordinator can discuss this with the CF&S social worker involved. The Duty social worker in the CF&S Duty and Assessment team (DAT) will need to be contacted if the case is not open to any one.

Young Carers

Resource Officers for Carers (Mental Health) work within the Community Mental Health Teams. Their role is to assess young carers as well as adult carers. With the mental health service user's Care Co-ordinator, they write up a care plan for the carer. Their involvement ends when the care package is set up, until it is reviewed. The following protocol mainly focuses on potential children in need identified by the Resource Officers as most referrals are likely to come through this route.

The Resource Officer (RO) is referred a young carer to assess by the mental health service user's Care Co-ordinator (CC). The RO completes the assessment, and sets up the care plan with the CC. This may include a number of actions:

- Identification of Mental Health services that need to go into the parent to support the young carer – Action by the CC
- Referral to the Young Carers Project – Action by the CC
- Referral to the Carer's Spot Purchasing Budget, held by the Carers Project Officer at the Carers Centre – Action by the RO
- Referral to other appropriate forms of support – Action by the RO
- Referral to CAMHS – Action by the RO/CC
- Referral to CF&S to be assessed as a 'Child in Need' – Action by the CC/RO
- Referral to CF&S due to Child Protection concerns – Action by the CC/RO

Process for making a referral under the Assessment Framework

The RO speaks to a Duty worker in the CF&S DAT about whether it would be an appropriate referral. No names are given at this stage due to confidentiality.

If the child is not a young carer, the CC will still follow this process. The RO, and the practice supervisor or line manager, can be called upon to act as a resource offering

information and advice on the process. They will not be part of the referral.

Process for making a referral under the Assessment Framework

- The RO speaks to the CC about the referral
- The CC, with the RO, discusses it with the parent. Their agreement is sought, and permission given to make the referral
- If they agree then a referral is made. The parent signs the referral form, and agrees what information can be shared with DAT
- The CC will make the referral, but the RO will add information about the young carer where appropriate
- The main person expected to complete the referral form will be the CC who knows the parent. The CC will pass on any relevant information, which will include CPA documentation, but this must be agreed by the parent.
- The RO will add any relevant information
- The RO and CC will be expected to attend any meetings that the DAT call

Relevant legislation for Children in Need and Young Carers

The process of the Care Programme Approach (CPA) is clearly intended to deliver care to meet the individual needs of service users. However, these needs often relate not just to the service user, but also to the lives of their family. The CPA should take account of this, in particular the needs of children and Young Carers of people with mental health problems, and must comply with the Carers (Recognition and Services) Act 1995 and National Service Framework for Mental Health (Standard 6 - Caring for Carers).
(From *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach – a policy booklet* SSI/NHS Executive October 1999)

The provisions of the *Carers (Recognition and Services) Act, 1995*, cover “children and young people (under 18) who provide or intend to provide a substantial amount of care on a regular basis”. Under this act a Young Carer has the right to request to an assessment of their own needs. The *Carers and Disabled Children Act 2000* further enforced the rights of a Young Carer to an assessment of their needs, even when the parent has refused a service from the local authority.

The *National Service Framework for Mental Health Modern Standards and Service Model Standard 6 – Caring for Carers* (Department of Health 1999) states that;

All individuals who provide regular and substantial care for a person on CPA should:

- Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- Have their own written care plan which is given to them and implemented in discussion with them

While not all young carers are children in need, and not every child whose parent has mental health problems is a young carer, patients/service users should be

supported in their parenting role. Services may need to be provided so the child has the opportunity for a full education, and is able to benefit from leisure and social activities.

The *Framework for the Assessment of Children in Need and their Families* (Department of Health, Department for Education and Employment, Home Office, 1999) explicitly states;

"Young carers should not be expected to carry inappropriate levels of caring which have an adverse impact on their development and life chances. It should not be assumed that children should take on similar levels of caring responsibilities as adults. Services should be provided to parents to enhance their ability to fulfil their parenting responsibilities".

APPENDIX A - OOH sharing of information/liaison with Children's Services on cases involving children in need/ child neglect or significant harm.

General Note on services operating outside of normal 9-5 Mon-Friday

i. It is recognised that important services and interventions take place outside of normal 9-5 office hours involving children and families. The OOH Mental Health Team operates from 3 p.m. to 11 p.m. weekdays and from 12- am to 11 p.m. weekends and bank holidays. Outside of these hours, the EDS service maintains a 24 emergency response service, covering statutory mental health work on behalf of WAMHS in the city of Brighton.

ii. Most of OOH work is direct work with adults with mental health needs. However, there are significant occasions when children in need issues are discerned. Child neglect/significant harm issues can also be picked up by OOH, although proportionately this will normally be routed direct to EDS out of hours, or if they are discerned by OOH there is a fast track referral through to EDS.

iii. The protocol therefore separates children in need and child neglect/significant harm into two categories and starts with children in need as this tends to be potentially the more ambiguous area. This document seeks to assist staff in OOH to balance Human Rights issues of parents/adults against their statutory duties to protect the interests/welfare and rights of children as of paramount importance.

A Children In need

OOH protocols for dealing with information sharing/liaison on cases with children in need issues

1. In all referrals taken by OOH, efforts should be made to establish family composition, note names and d.o.b of any children and make a record of adult's names in household with parental responsibility

1.1 A check on data base should be made to Carefirst to ascertain if family known to CF&S

2. If at the point of referral the referrer has already highlighted children in need issues, OOH should clarify with the referrer whether at this stage CF&S have been informed of concerns.

2.1. If not, OOH should ask referrer to consider sharing information with CF&S at this stage or reach agreement that OOH will now liaise with CF&S direct

3. In the course of work on cases, where there are children in need issues, OOH ***will always share information with colleagues in CF&S***

4. Dependent on the level of concerns, OOH SP needs to consider the following 3 options:

(Note: if OOH is unsure of the need of urgency and wishes to evaluate this further, OOH will discuss with EDS colleagues who have a generic child care experience base)..

4.1 If the children in need issues are urgent and needing quick intervention OOH will refer to colleagues in EDS.

Where such referral are made to EDS, EDS will then be the primary agency dealing with the 'child in need' issue. OOH will fax on to the Manager at DAT for next working date all OOH recording and cover member, outlining key issues and indicating time of referral to EDS and agreed action at point of referral to EDS.

4.2 (in cases where OOH is making a referral to CF&S for immediate action/attention for the next working day) – faxing to Manager DAT the recording sheets of OOH intervention together with summary cover note to arrive next working day 9 am

Or

4.3 (*see reference 2.4.1 in joint protocol-re responsibility to consult*)
(in cases where OOH is not making a referral but wishes to flag up to other parts of the services that there has been contact between OOH and the family where there are children in need issues).-preparing a summary memo on OOH involvement and faxing to Duty Manager DAT CF&S for next working day 9am

Note : When working with parents where there are children in need issues, OOH needs to advise them that they will be sharing information with other relevant parts of the service, whilst reassuring them that this is to maximise support through appropriate sharing of information with agencies

Protocol for CSW staff

As above, but also to report on directly to S.P on duty any cases where they Children in Need/Child Protection issues.

5. References
Joint Working Protocol
ACPC CP procedures
OOH Operational instructions

B: Neglect/Significant Harm

OOH protocols for dealing with information sharing on cases with children presenting with neglect/significant harm.

1. In all referrals taken by OOH, efforts should be made to establish family composition, note names and d.o.b of any children and make record of adult's names in household with parental responsibility

1.1 A check on data base should be made to Carefirst to ascertain if family known to CF&S

2. If at the point of referral the referrer has already highlighted children in neglect/child protection issues, OOH should clarify with the referrer whether at this stage CF&S have been informed of concerns.

2.1. If not, OOH should ask referrer to consider sharing information with CF&S at this stage or, in exceptional circumstances reach agreement that OOH will now liaise with CF&S direct

3. In the course of work on cases, where there are child neglect/significant harm issues, OOH ***will immediately refer to Children's Services either via DAT (if before 5 am weekday) or most commonly via EDS if outside of these times.***

4. All case records from OOH involving contact with a family where issues of neglect/significant harm have been discerned will be faxed to the Duty Manager DAT by 9 am the following working day, with a covering memo by the OOH Senior Practitioner outlining the key points and indicating the steps taken to refer/ involve the OOH children services from EDS

4.1 A copy of this memo and a copy of the case papers to also to be copied to the care co-ordinator and the OOH RM

5. Note: When working with parents where there are child neglect/ significant harm issues, OOH needs to advise parents that they will be sharing information with other relevant parts of the service, whilst reassuring them that this is to maximise support through appropriate sharing of information with agencies

6. Protocol for CSW staff
As above, but also to report on directly to OOH S.P on duty any cases where they Child Neglect/ Significant Harm issues present..

5. References
Joint protocol
CP procedures
OOH Operational instructions

APPENDX B Parents with Learning Disabilities

Guidelines

People with learning disabilities have significant deficits in intellectual and social function. While there are formal measures of intellectual capacity, these provide hypothetical information about functioning and should not be used to make judgements in the absence of directly observable evidence. The government Strategy for Learning Disability – Valuing People, makes clear that people with learning disabilities can be good parents and should be supported in their role. The document notes that they are among the most socially and economically disadvantaged groups and likely to be very demanding of services that are, as yet, quite fragmented.

A further point, not noted by Valuing People, is that those with severe learning disabilities are more likely to be living in residential services, less likely to be developing sexual relationships and so less likely to be parents. Those that do are already receiving support and matters of child protection would be considered within that context. Our main concern is with those adults who live more independently, have lifestyles that might be familiar to many other adults, and are often on the fringes of other disadvantaged groups, some of which are abusing and exploitative. Child protection procedures can often threaten the fragile assertion of normality such people have acquired, leading sometimes to defensive and uncooperative behaviour.

This guide lists difficulties that are common in but not exclusive to people with learning disabilities. For many of these difficulties, causes other than learning disability may be present and so the task may be to identify the deficit and its impact before making an assumption about causality.

Problem	What it looks like	How to help
Learning	Able to take in information only in small chunks. May not be able to generalise from learning setting to home setting. May not be able to integrate learning to form an overview of parenting competence. Parenting tasks can become a burden on intellectual capacity because they are separate and not part of a set of principles.	Give information in small chunks and check understanding by asking the person to tell you what it means. Use combinations of video, drawings, written cards and photos. When teaching a skill, ensure setting and equipment are as much like those at home as possible.
Memory	Can be context dependent so may recall information only in the setting in which it was presented. May recall selected parts of information and so be unable to integrate. Some people recall only the first part of a message, some only the last. Many recall unrelated items or may confabulate to fill in the gaps.	Use lists with pictures or diagrams and clear stages for any task. Instructions need to be short, clear and listed.
Literacy and Numeracy	Some people appear from their verbal expressions to be quite capable but this may rely on stock phrases. Receptive language can be very limited, especially in professional encounters. Many are unable to read or write effectively, some can read the words but have no knowledge of their meaning or cannot integrate them to form a message. Professionals tend to use sophisticated, complex language structures with a reading age of around 17 years. The UK average is about 10 years but many people with learning disabilities	Avoid sophisticated language; keep sentences short with no 'ifs', 'buts' or double negatives. Make simple charts or drawings to measure amounts or use a concrete marker for e.g. making up bottles. Be simple but not simplistic. Try not to seem patronising.

	may function at less than 6 years in this area. This is not a mental age. People with learning disabilities can be educationally disadvantaged. Most do not recognise fractions or decimals, and cannot do division sums so working out proportions, budgeting, giving medicines etc can be difficult.	
Flexible Thinking	This is about applying old knowledge to new situations or developing novel solutions to problems. Many people with learning disabilities find it difficult to be flexible because they operate according to a set of rules rather than a set of principles. Some do not have insight into this difficulty and may insist on adherence to an inappropriate rule or fail to anticipate a need to change.	Teach problem solving by setting scenes and asking 'what if?' questions. Draw up the results together to take home or keep in a loose leaf book.
Emotional Development	Some people with learning disabilities have not moved beyond the developmental stage that puts themselves at the centre of any activity and so, while they may be able to show intellectually that they know how to behave in a given situation, emotionally they are unable to follow through. There are differences according to specific groups. People with Down's Syndrome tend to be more emotionally intuitive and insightful than most other people with learning disabilities while	Teach rules instead. Make your goal mature **behaviour** where emotional maturity itself might not be achieved. Sometimes externally driven skills can become internalised.

	those with an Autistic Spectrum Disorder are considerably less so. People with DS seem more able to connect emotionally with people, to anticipate a need, and to seek support.	
Acquiescence and Suggestibility	Many people with learning disabilities are easily led into agreeing with someone or changing their answer if they think they were wrong. This can give the impression that they understood something they did not (because they said yes when asked), that they are unreliable because they did not do the thing they said they would do (they had not understood but said they did), or that they lie (they changed an answer because they wanted to be right). When challenged, people can become defensive and aggressive or they may withdraw, leading to views that they are uncooperative and difficult. Some people will agree just to please others, saying they will do something when they can't.	Use open non-leading questions. Ask for the person's recall of something before asking questions. Don't make assumptions about understanding and don't always take Yes for an answer!
Initiative	This depends on both problem-solving and social functioning capabilities. Many people with learning disabilities expect to be taught something rather than work it out for themselves. This is not laziness, it seems to be an assumption that knowledge about things is an entity that can be passed from expert to learner and if	As for flexible thinking. Develop new scenarios, possibly in groups, role play actions, get participants to generate ideas and solutions. Only make corrections if really necessary.

	they don't know something, it is because they have not been taught. Some people have no expectation of developing their own solutions and so can seem passive and incompetent especially if they make no attempts to seek social contacts that might be helpful. Behaviour and skills are more likely to break down under stress e.g. physical, emotional, financial or group pressures.	

Problem	Difficulty	Possible Cause	Other Causes
Poor emotional contact with child or emotional abuse	Unable to perceive, acknowledge or prioritise child's needs. Unable to empathise or see from the child's perspective.	Has not reached developmental stage that gives capacity to put own needs second May be on Autistic Spectrum dimension with or without diagnosis. Unable to perceive the needs of others or to empathise. Some 'know the words but not the music'.	Mental health problems, substance or alcohol misuse, psychological problems, victim of abuse, immaturity, personality disorder. Abnormality of own childhood experiences.
Physical neglect of child	Unable to perceive, acknowledge or prioritise child's needs	As above. Also lack of knowledge or experience, unable to read instructions on packaging or given by professionals, unable to tell time or organise time leading to irregularity of routines or no routines at all. Those with ASD characteristics may have firm beliefs that are difficult to challenge	Poverty, social isolation, depression, abusive partner, mental health and other problems as above

Physical abuse of child	Poor emotional resources due to own stage of development, unrealistic expectations of child's responsibility or capability	May not understand child is not a small adult and so is not responsible for actions, blaming for being 'wrong', impulsivity due to poor executive functioning, following 'rules' rather than principles.	As above. Poor or disordered models of parenting, experience of personal abuse
Sexual abuse	There is no evidence that wilful sexual abuse of a child would be directly due to learning disability	Some people with learning disabilities are also sex offenders and paedophiles. Quite often it seems that their capabilities in the social requirements of their preferred activity are disproportionately superior to their more general coping skills e.g. grooming and social manipulation of victims. Some abuse may occur as the result of pressure from an abusing partner and may be committed in ignorance or knowledge of its implications or in order to 'keep in' with the partner.	Sex offender profile or poor protective capabilities. May be unable to protect self in abusive environment

In all situations of suspected abused or neglect, there may be indications in pets kept by the family. Evidence of animal abuse has been linked to abuse of other vulnerable targets in the same environment. There is increasing pressure for cross agency work in this regard between social care, health care and animal welfare.

Appendix C

GUIDELINES FOR WORKING WITH SUBSTANCE MISUSING PARENTS

RECEIVING A REFERRAL

- If the patient has children who live with them, then a home visit needs to be undertaken

- If the patient is NOT known to the service and is self-referral (i.e. no other information for a risk assessment can be gathered) then 2 members of staff need to do the DV. They do not necessarily have to be staff members of the Substance Misuse Service; for example, a health visitor, Oasis worker or social worker may be more appropriate.

When making the appointment be mindful of the time you offer e.g. Do not book the appointment at the same time as school runs etc.

AT THE ASSESSMENT

Before starting the assessment it is essential that you explain that confidentiality will be broken if there are any child protection concerns.

When undertaking the assessment use SCODA guidelines (attached) and be particularly mindful of the following:

- It is good practice to ask to look around the accommodation

- It is good practice to ask to be shown where the drugs are kept and advise on how to store appropriately

- It is important to ask where the patient is using drugs, where the child(ren) are when they are using

- Try and establish if there are any non-using or using others within the household and is there anybody who is a nonuser within the support network

- Get consent to liaise with other agencies

FOLLOWING ASSESSMENT

You need to do a CARE FIRST check with Social

Services.

Phone 01273 295373 or 296000 and ask them to check if the family are known to them. Be clear you are making a check not a referral at this stage.

You will need names of the children, DOB and address (Children's surname may be different from the parents)

If they are known, establish if the case is open and if so who is the social worker and make contact with them.

If they are known but not open, establish what was the prior involvement.

Liaise with other children's services if appropriate.

Write a letter to the GP surmising the assessment, conclusions and treatment plan. Cc to Social Worker (if open) and the Health Visitor/School Nurse.

- The point of checking CARE FIRST is to help inform your decision as to whether to make a child protection referral.

- If there is a child protection involvement you do NOT need consent to speak to other professionals, though it is a good idea to inform the parents you are doing so.

- If the case is not open to Social Services you can not liaise with other agencies without consent as it breaches the Human Rights Act - however the self referral has a consent clause allowing collection of information in the interests of the child.

- If Social Services (Child Protection) ask for information on a patient you must give that information.

- If you have any child protection concerns, discuss them with your Team Leader as soon as possible, and in Team meeting document these discussions.

ONCE IN TREATMENT

The Substance Misuse Service obtains urine specimens in accordance with clinical need as set out in a patients care plan. It is not responsible for obtaining any additional samples required as part of a child protection plan, whether or not this is at the direction of the court.

Notes need to be written contemporaneously (within 24 hours of contact).

If there are any changes in drug using behaviour or any changes to the treatment plan or any changes to risk you need to inform the allocated social worker.

MAKING A CHILD PROTECTION REFERRAL

Use the referral form (enclosed).

The referral must be evidence based, the concerns must be substantiated and backed up with examples.

Unsubstantiated general concerns do not constitute a referral.

You must tell the patient that you are making the referral - if you do not, Social Services will

The only exception is if by doing so you would be putting the child and/or yourself at risk.

If the patient is pregnant, make the referral to: The Royal Alexandra Hospital Social Work Dept, Dyke Road, Brighton.

If the patient has children but is not pregnant, make the referral to: DAT, Bartholomew Square, Brighton.

The referral needs to be in writing.

The only time to make a phone referral in the first instant is if you feel there is immediate risk to the child/ren.

If you are making a ‘Child in need’ referral, consent must be obtained before it can be progressed.

Before making a child in need referral, you need to consider if it is the most appropriate place and if other community services are not better placed to offer support.

WRITING AN INITIAL CASE CONFERENCE REPORT

Even if you are attending a case conference you need to take the written report to have in to the chair.

When writing the report you need to include:

Date of conference
NAME, DOB, ADDRESS
When and where you assessed the patient
Report what the patient was using at point of assessment including urine results
Prescribed medication
How long the patient has been known to the Service
Drug using history
Past episodes of treatment and how successful they have been
Physical health
Mental health
Forensic history
Social circumstances
Treatment plan including frequent of urine samples and results

DATE STARTED IN TREATMENT AND WHAT TREATMENT

Attendance
Engagement in treatment and other agencies
Change to drug using behaviour since started in treatment.

WRITING ANY FURTHER CASE CONFERENCE REPORTS

Even if you are attending a case conference you need to take the report to hand in to the chair

Write an update, including:
Compliance in treatment
Engagement with services
Urine sample results
Review of treatment
Likely sequence of events
Change in drug using behaviour

CORE GROUPS

Core groups are groups of professionals working with the family who complete the Child protection Plan and put it into operation.

If you attend you do not need to take a written report

If you do not attend, send a brief update

S.C.O.D.A. Guidelines
Assessing risk when working with drug using parents

Parental drug use

- Is there a drug free parent, supportive partner or relative?
- Is the drug use by the parent Experimental? Recreational? Chaotic? ?Dependent
- Does the user move between categories at different times? Does the drug use also involve alcohol?
- Are levels of child care different when a parent is using drugs and when not using?
- Is there any evidence of coexistence of mental health problems alongside the drug use? If there is, do the drugs cause these problems, or have these problems led to the drug use?

Accommodation and the home environment

- Is the accommodation adequate for children?
- Are the parents ensuring that the rent and bills are paid?
- Does the family remain in one area or move frequently, if the latter, why?
- Are other drug users sharing the accommodation? If they are, are relationships with them harmonious, or is there conflict?
- Is the family living in a drug using community?
- If parents are using drugs, do children witness the taking of drugs, or other substances?
- Could other aspects of the drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

Provision of basic needs

- Is there adequate food, clothing and warmth for the children?
- Are the children attending school regularly?
- Are children engaged in age-appropriate activities?
- Are the child's emotional needs being adequately met?
- Are there any indications that any of the children are taking on a parenting role within the family (e.g. caring for other children, excessive household responsibilities etc)

Procurement of drugs

- Are the children left alone while their parents are procuring drugs?
- Because of their parent/s drug use are the children being taken to places where they could be 'at risk'?
- How much are the drugs costing?
- How is the money obtained?
- Is this causing financial problems?
- Are the premises being used to sell drugs?
- Are the parents allowing their premises to be used by other drug users?

Health risks

- If drugs and/or injecting equipment are kept on the premises, are they kept securely?

- Are the children aware of where the drugs are kept?

- If parents are intravenous drug users:

    - Do they share injecting equipment?
    - Do they use a needle exchange?
    - How do they dispose of syringes?
    - Are parents aware of health risks of injecting or using drugs?

- If parents are on a substitute prescribing programme, such as methadone:

    - Are parents aware of the dangers of children accessing this medication?

- Do they take adequate precautions to ensure this does not happen?

- Are parents aware of, and in touch with, local specialist agencies who can advise on such issues such as needle exchange, substitute prescribing programmes, detox and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?

Family social network and support systems

- Do parents and children associate primarily with:
    - Other drug users?
    - Non-users?
    - Both?
- Are relatives aware of the drug use? Are they supportive?
- Will parents accept help from the relatives and other professional of non-statutory agencies?
- The degree of social isolation should be considered particularly for those parents living in remote areas where resources may not be available and they may experience social stigmatisation.

Parents perception of the situation

- Do the parents see their drug use as harmful to themselves or their children?
- Do the parents place their own needs before the needs of their children?
- Are the parents aware of the legislative and procedural context applying to their circumstances (e.g. child protection procedures, statutory powers)?

Appendix D

ASSESSMENT OF PARENTING CAPACITY GUIDANCE

This section indicates to adult workers the areas to consider at an early stage. It may provide the basis for a consultation with or referral to the Children and Families Duty and Assessment team/Long Term Teams, or a discussion with health colleagues (health visiting/school nursing/community paediatrics/CAMHS/other adult services).

The word **parent** is used to indicate any adult in the household acting in a parental capacity, whatever the relationship to the child.
The assessment should consider whether parental medical or developmental problems are having an effect on the child. If so, is it long term or short term and are there any compensatory provisions? The assessment should also consider whether there are remedial measures that can be taken (eg. Alteration in medication or timing of medication). Are the problems repetitive? If yes, how is this impacting on the child?

Basic Care

Is the parent providing adequate food, drink, warmth, shelter, clean and appropriate clothing, adequate personal hygiene and appropriate medical and dental care? Is what the child is doing for him or herself under these headings age-appropriate? Is the parent handling the infant/child appropriately?

Ensuring Safety

Is the parent able to protect the child from harm or danger, in terms of recognising hazards both in the home and elsewhere, and in terms of protection from contact with unsafe adults/children, or from self-harm?
Is the parent able and willing to put the child's needs before his/her own?
Is the child involved in the parent's symptoms?
Does the parent have more than one psychiatric diagnosis, or dual diagnosis with substance abuse? If so, how does this impact on the child's safety?

Emotional Warmth

Is the parent able to ensure that the child's emotional needs are met by secure, stable and affectionate relationships with significant adults?
Does the parent offer comfort to the child when required?
Does the parent make appropriate eye and physical contact with the child?
Is the child caring for the parent?

Stimulation

Does the parent promote the child's learning and intellectual development by interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play?

Is the child attending school/playgroup? Is the child experiencing other social activities?
Does the parent enable the child to experience success and help him or her to meet challenges?

Guidance and Boundaries

Does the parent enable the child to regulate their own emotions and behaviour by demonstrating and modelling appropriate behaviour and control of emotions by setting boundaries and by effective age-appropriate discipline for the child?
Does the parent over-protect the child from exploratory and learning experiences?

Stability

Is the family environment sufficiently stable to enable the child to develop and maintain a secure attachment to the primary care-giver(s)?
Does the parent offer a consistent response to the same behaviour of the child, but also develop responses according to the child's developmental progress?
Does the parent enable the child to stay in contact with important family members and significant others?

Protective factors

Research suggests children are less likely to be affected by parental mental illness when it is:

- mild
- of short duration
- un-associated with the family discord, conflict and disorganisation
- un-associated with the family breaking up
- linked with children having good social networks, especially with adults

The above protective factors can also be considered when there are other parental medical or developmental impairments. Supportive networks should be identified and/or developed if lacking.

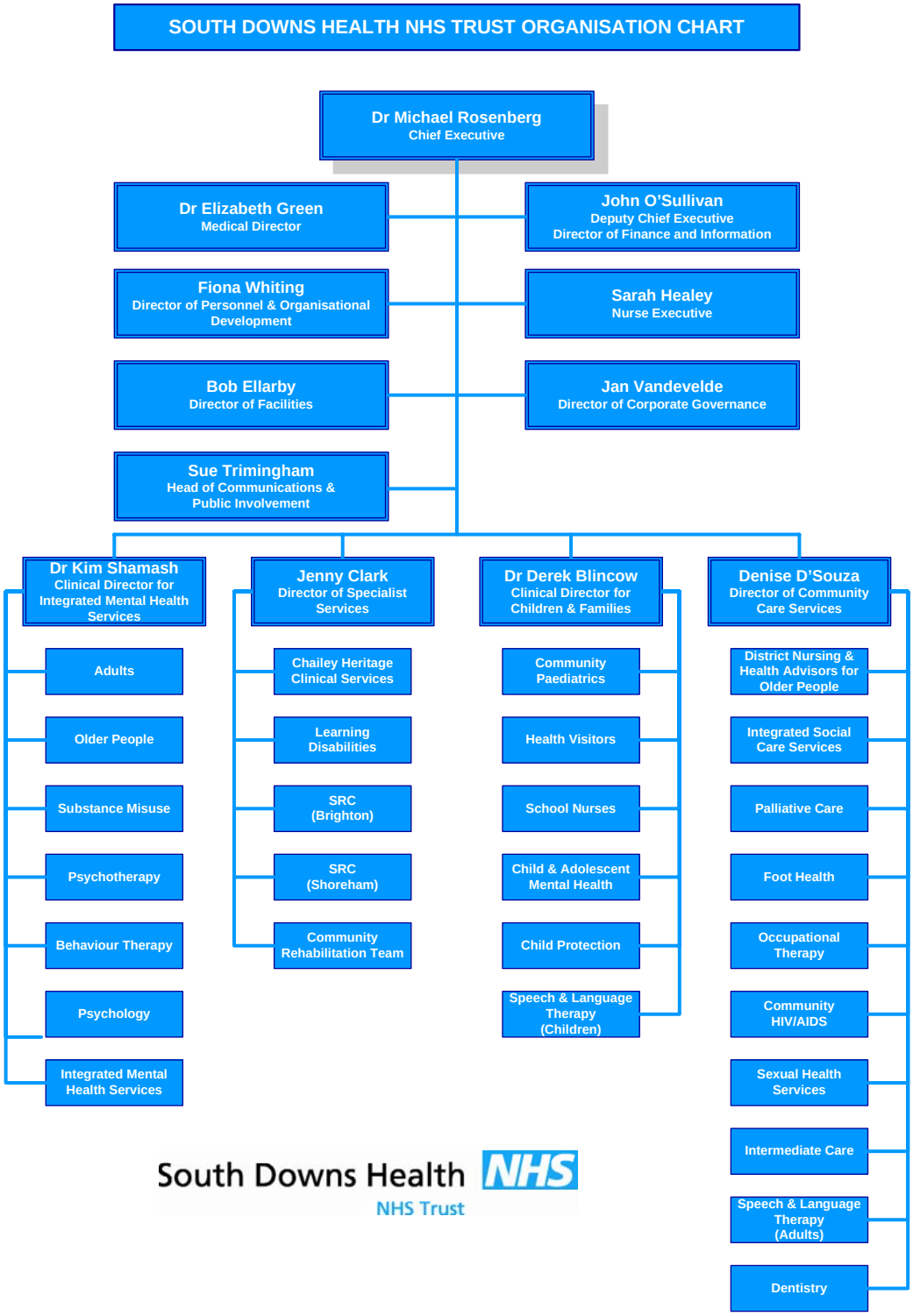
RELEVANT LITERATURE

Department of Health, Department for Education and Employment, Home Office: Framework for the Assessment of Children in Need and their Families (2000) The Stationery Office ISBN 0-11-322310-2

H Cleaver, I Unell, J Aldgate for the Department of Health: Children's Needs - Parenting Capacity: the impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development (1999) The Stationery Office ISBN 0-11-322278-5

Adrian Falkov: Fatal child abuse and parental psychiatric disorder in an analysis of 100 Area Child Protection Committee Case Reviews (1996) Department of Health.

Appendix E, SDHT Structure March 2004



Appendix E, Children and Families Directorate Structure, SDHT