



KBSP Multi-Agency Guidance

**A THINK FAMILY APPROACH TO SUPPORTING
AND/OR SAFEGUARDING CHILDREN WHOSE
PARENTS HAVE SUPPORT NEEDS**

May 2018

Contents

Introduction	4
The principles of good practice	5
1/ Think Family, Parent and Child.....	5
2/ Getting the Right Help at the Right Time for the Right Duration	6
3/Culture of Responsibility, Challenge and Escalation	7
Legal Framework	7
Parenting capacity	8
Adverse childhood experiences (ACEs)	8
Understanding Risk.....	9
Parents who find it difficult to engage	10
Confidentiality and Information sharing.....	11
Gillick Competency and Fraser Guidelines	13
Mental Capacity Act 2005	13
Who Assesses Capacity?	15
Lack of Capacity	15
Supervision	15
Training	16
THE THINK FAMILY PARTNERSHIP APPROACH	17
A Multi Agency Approach	17
Referrals to Children’s and Adults’ Services	18
Working Together 2018 and the role of the Lead Practitioner	18
Troubled families	19
Children’s Services	19
Checklist for Children Services	20
Case Management	21
Child Protection Conferences.....	21
Services working with Adults	22
Referrals to Adult Services Health and Social Care	23
Child Care issues	24
Specific Guidance	24
Young Carers	24
You can contact the Carers Support Centre using their online form.Parental mental health	25
Assessing the risk of parental mental health problems	27
Psychosis.....	28

Whole Family Approach to Parental Mental Health.....	29
Perinatal Mental Health	30
Red flag signs/activators.....	31
Whole Family approach to Perinatal Ill health	32
Local Contacts	32
Alcohol and Drug problems.....	35
Harm reduction information to parents	36
Undertaking assessments	36
Implication for and effects on Parenting	37
Referrals to children and family services	38
Issues for a practitioner to consider when assessing parental substance use	39
Local Contacts	41
Parents with a Disability	45
Equal opportunities.....	45
Pre and post- natal check up	47
Assessment	47
Parents who offend	48
Prison	49
.....	50

Consultation with parents

This consultation was supported by parents that work with Bristol Drugs Project

What parents want less of:

- ✚ Actions that make the parent feel isolated, such as when children need to be spoken to sometimes no explanation is given as to the reason why;
- ✚ More drug tests to evidence abstinence so they can prove they are doing well;
- ✚ Stigma and judgement. It is difficult asking for help;
- ✚ Not knowing about things that may happen. Professionals to explain what is happening and when;
- ✚ Not having enough support.

What Parents want more of:

- ✚ More updates from Social Care. Sometimes there was no communication even when they arranged to do so;
- ✚ More detailed communication. When their children have statutory involvement with safeguarding services the process is not explained properly and it leads them to feel more isolated. They feel social care have a responsibility to help keep them engaged;
- ✚ More understanding and support provided through difficult times with a non stigmatising approach;
- ✚ Compassion. It is difficult asking for help;
- ✚ More training needed when managing cases involving domestic violence where the victim is kept separate from the perpetrator;
- ✚ Openness when talking about interventions and their children. This brings more honesty from parents.

Introduction

This multiagency guidance has been written for professionals working with parents whose complex needs impact on their ability to care for the children around them. For example parents and carers who have mental health issues; disabilities; have drug and alcohol problems; effected by domestic abuse and/or have involvement with the Criminal Justice System. In many of the cases in which there are concerns about a child's welfare, parents will be facing at least one these issues.

Cleaver and Walker (2004) found that domestic abuse, substance misuse, mental health problems and/or learning difficulties was present in three-quarters of the 866 initial assessments they audited in 24 local authorities in England. In many of the assessments, several of these complex needs/issues were identified making it clear that they do not occur in isolation and identifying a complex interaction between them. Further to this, an [Ofsted \(2010\) report 'Learning lessons from Serious Case Reviews'](#) noted that the most common issues (relating to the children's families) were domestic violence, mental ill-health and drug and alcohol misuse. It is important to note however that other triggers such as pregnancy, separation, divorce, bereavement, imprisonment, discharge from prison, return from active military service and financial difficulties may also cause emotional distress and are associated with increased risks to the whole family.

This guidance seeks to embed good practice so that the child's needs are not overlooked by adults' services where the focus may be on the adult in front of them and likewise for children's services to not overlook the adults' needs. It will seek to ensure services adopt our principles of good practice which include a **Think Family** approach where it recognises that excellent children's services and excellent adults' services are not enough in isolation.¹ Supporting, safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, is dependent upon effective joint working.

'It is our expectation that services work in accordance with the high level partnership arrangements described in this document as a minimum.'

Parenting at any stage can be a challenge and requires a great deal of physical and emotional effort. Most parents and carers have the capability to provide 'good' or 'good enough' parenting for their children. They are able to access universal services to support their health, education and leisure needs however sometimes, a usually

¹ <http://data.parliament.uk/DepositedPapers/Files/DEP2008-0058/DEP2008-0058.pdf>

capable parent will have such overwhelming needs of their own that they may need more intensive support to assist them in their parenting role. Children's health and development, and sometimes their safety, may be affected by the difficulties their parents are experiencing which may adversely affect their capacity to respond to the needs of their children and/or vulnerable adults in the family. If this is short term, then providing the children's and adults physical and safety needs are met, most have the resilience to overcome the stress of this with the support of their friends and family.

Parents with complex needs may have experienced trauma or adverse childhood experiences themselves where they internalise their negative beliefs into adult lived experiences. They may well feel overwhelmed and therefore face enormous daily challenges. It is important not to judge or stigmatise the choices made by parents, but recognise that choices often come from negative beliefs about who they are and their own ability to parent. It is important to remember that parents are the experts on their own life experiences and what they need from services.

Throughout this guidance *child* refers to anyone who has not reached their eighteenth birthday, including unborn children. *Parent* refers to parents/ carers, relationships with extended family members, friends or acquaintances who have access to the child (enough to cause harm to the child).

The principles of good practice

Our multi agency approach in Bristol will be guided by the following principles:

1/ Think Family, Parent and Child

Inappropriate tasks and responsibilities undertaken by a child or young person which adversely impact their emotional, physical, educational or social development should be prevented by providing adequate and appropriate support to the parent(s) and their family.

This means thinking about the child, the parent and the family, with adult and children's services working together to consider the needs of the individual in the context of their relationships and their environment whilst also recognising diversity and personal preferences. This will avoid services having to respond to each problem, or person, separately.

The aim of Think Family as summarised in the original messages from *Think Family: Improving the life chances of families at risk* (2008) are as follows:

- There should be no 'wrong door' to services. Any contact a family member has with a service is an opportunity to guide them into other services that they

need. To transform life chances and break the cycle of disadvantage, services must go further;

- Practitioners should actively think of the needs of the family as well as, and in relation to, the needs of the service user;
- The focus should be on families' strengths and should aim to develop the family's capacity to look after their own needs;
- Support given to families should be relative to their need; the greater the need, the greater the support.

Work with the wider family should always be viewed in relation to 'how will these actions improve outcomes for the child'. This will be achieved by building on strengths as well as identifying difficulties using the Signs of Safety model as well as hearing the child's voice and that of their parent and carer. Children's needs are usually best met by supporting their parents to look after them. Participation of parents and carers ensures that they are able to contribute to assessments and plans in relation to them and their families, and can identify and build on strengths and skills to make lasting changes. Services must provide a non-stigmatising service that encourages social inclusion for all users.

2/ Getting the Right Help at the Right Time for the Right Duration

Professionals must focus on intervening at the earliest opportunity. Preventative and early help responses are critical to avoid issues from escalating and families experiencing further harm. Support needs should be addressed by enabling parents to access universal and community services wherever possible, as appropriate. The services provided at this level will provide the consistency needed by the child and family. Additional support needs should be met by using this support to prevent the child and family needing to access higher tier services. This could be through a single or multi agency response with timely provision.

When there is an escalating need(s) a multiagency approach is required. Targeted support, specialist assessment and service provision will be used to identify what is in the best interests of both parents/carers and children. Regular monitoring and reviews of interventions and support to families to ensure a co-ordinated approach to long term multi-disciplinary work will ensure that child(ren) are protected and parents are supported to parent effectively.

Statutory involvement is required when the child(ren) require intensive support and protection as a result of their parents complex needs. To ensure children's safety and welfare, many of these families will require support from both children's and adults' services. These children will require protection under s.17 and s.47 Children Act 1989. This is the threshold for child in need, child protection, and looked after children. At this level of need, social workers, in partnership with families and other agencies, will assess what services, from which agencies, are called for. A

collaborative approach would ensure that parents are recognised as having needs in their own right, but the impact of those needs on their children becomes part of a multi-agency response. For further guidance read [Bristol's Multi-Agency Threshold Guidance](#). This provides a framework for all who work with children and families to provide early help and targeted and specialist support for children, young people, their families and carers.

3/Culture of Responsibility, Challenge and Escalation

Each individual is accountable and responsible for the child and adult. If a need is identified that can be met then the requirement to take action with the confidence to intervene and challenge positively when appropriate must be taken. Embedding appropriate challenge within an organisation is pivotal to ensuring good working practice and positive outcomes for children and their families. Please refer to the [KCS Escalation Procedure](#) for children and [KAS Escalation Procedure](#) for adults.

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 Services (social care) staff;
- if adult and children's services are providing services to a family, staff communicate and agree interventions;
- appropriate staff are invited to relevant planning meetings;
- staff participate in the relevant planning meetings.

Legal Framework

The legal framework, covering all statutory organisations, that underpins effective joint working across adults and children's services is the Children Act 2004.

Reference should also be made to:

- [The Care Act 2014](#), and the [Care and Support Statutory Guidance](#), Department of Health & Social Care;
- [Working together to Safeguard Children](#) : A guide to multiagency working to safeguard and promote the welfare of children, HM Government 2015;
- [Safeguarding Adults Multi Agency Policy](#);
- [Bristol KCS Threshold Guidance](#).

The multiagency policy and procedural framework that underpins effective joint working across adults and children's services in Bristol is:

- [KBSP Website](#) for local policies and procedures and/or;

- [South West Child Protection Procedures \(SWCPP\)](#) which offer a comprehensive set of step by step guides to professionals about what to do if they are concerned about a child.

Parenting capacity

A simple definition for parenting capacity that needs to be applied when making a decision and conducting an assessment is: "the ability to parent in a good enough manner long term" (Conley, 2003).

According to a survey of practitioners' perceptions of 'good enough' parenting contained four elements, these were:

- meeting children's health and developmental needs;
- putting children's needs first;
- providing routine and consistent care;
- acknowledging problems and engaging with support services.

From the same survey, risky parenting was associated with:

- neglecting basic needs; putting adults' needs first;
- chaos and lack of routine;
- and an unwillingness to engage with support services.

Kellett and Apps, 2009.²

Adverse childhood experiences (ACEs)

Adverse childhood experiences (ACEs) include a range of stressful events that children can be exposed to when growing up. Evidence shows that children who are maltreated or who grow up in homes with problems such as domestic violence, drug or alcohol problems or criminal behaviour have poorer educational and employment prospects are more likely to develop health-harming and anti-social behaviours, more likely to perform poorly in school and more likely to be involved in crime.³

Similarly, the range of different adversities used can be grouped under eight broad headings:

- poverty, debt, financial pressures;
- child abuse/child protection concerns;
- family violence/domestic violence;

² Kellett and Apps 2009 <https://www.irf.org.uk/report/assessments-parenting-and-parenting-support-need>

³ http://www.cph.org.uk/wp-content/uploads/2016/05/Adverse-Childhood-Experiences-in-Hertfordshire-Luton-and-Northamptonshire-FINAL_compressed.pdf

- parental illness/disability;
- parental substance abuse;
- parental mental illness;
- family separation/bereavement/ imprisonment;
- parental offending, anti-social behaviour.

Research Studies in Hertfordshire, Luton, Northamptonshire and Wales concluded that preventing ACEs or intervening early would not only lessen the prevalence of health-harming behaviours and prevent unintended teenage pregnancy, but also prevent violent behaviour, thus helping to break the cycle of adversity that families can become trapped into.

"By stopping abuse, neglect and other harmful experiences faced by children we could prevent around a third of all high-risk drinking, a quarter of smoking and as much as 60 per cent of violence in adults."⁴

Further reports detail how Adverse Childhood Experiences are associated with chronic ill health in later life such as the development of cancer, heart disease, diabetes and ultimately premature death therefore preventing or intervening at the earliest opportunity must be a principle that is embedded within all agencies.

Understanding Risk

The needs and issues facing some parents and carers are known to be associated with greater risks to both them and their children. This may relate to particular health or social behaviours of the parent or the danger to their physical health or well-being. This may be made worse by the social stigma attached to the problem of the parent or carer or by professionals being as overwhelmed as by the complexity of dealing with the problems that they face.

The risks particularly associated with mental health, drug and alcohol problems 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 or other violent crime. ([New Learning from serious case reviews: a two year report for 2009 DFE – RR226](#))

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. Practitioners

⁴ <http://www.wales.nhs.uk/sitesplus/888/page/88504>

must be able to recognise the family's strengths and distinguish between immediate concerns for the child's safety and wellbeing and risks which can be mitigated with appropriate support ([Cleaver et al., 2011](#); [NSPCC, 2015](#)).

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. "Risk management cannot eradicate risk; it can only try to reduce the probability of harm" ([The Munro Review of Child Protection Part One: A Systems Analysis, Professor Eileen Munro, and Department for Education 2010](#)).

Parents who find it difficult to engage

Understanding the reasons why parents are not engaging with services is a key element to developing an approach that encourages their participation or deciding on interventions where non-engagement is a serious risk to the child's safety and welfare.

Parental reactions to intervention by services may vary from fear or mistrust to a general hostility towards authority which is based on previous poor contacts with agencies. Involvement with services is also bound to cause some stress to families particularly as involvement may be obligatory rather than through choice.

Parents who are failing to engage may:

- be reluctant or associate the provision of additional support as failing in their duty to provide good enough parenting;
- avoid contact with professionals, or the quality of contact may be poor and characterised by resistance, an unwillingness to provide information, and a general hostility and mistrust. Hostility with agencies may be based on a fear of loss of control of the home environment, and this may be particularly prevalent in cases where domestic violence is an issue. Parents may wish to maintain privacy and will resent outside interference, especially given the stigma of social work involvement with the family;
- miss appointments, deny access to the family home, keep children from attending school or nursery or prevent professionals from seeing the child alone;
- appear to engage with services on the surface, but their engagement is in reality a form of resistance or disguised compliance;
- fail to take advice, attend meetings or take up services, this could be due to parents not understanding the reasons for concerns or the role of the social worker and professional network, or what they are expected to do in order to

change the situation. Families from abroad may not have any knowledge of the English child protection or legal system;

- minimise concerns or divert attention away from the child's needs to their own by controlling discussions;
- manipulate the professional network by aligning themselves with one professional or targeting a professional for criticism;
- use threatening or hostile behaviour to deny or disrupt contact with the child or family;
- use complaints systems to change or control professional's responses;
- only activate change through external pressure from agencies and /or that change is sporadic, short-lived, or limited to one area of concern;
- avoid contact as they fear that information provided to professionals may be passed to other agencies with whom the family may have good reason to avoid contact, for example families who are concerned about their residence status in the UK.

Professionals need to consider whether parents are actively trying to cover up harm and abuse and their lack of engagement is a deliberate attempt to keep professional at a distance to hide the true situation, or whether more support is needed to help them engage. Professionals should consider the possible reasons for lack of engagement, for example if they are unhappy with any case decisions or the way in which the case is being conducted.

Confidentiality and Information sharing

Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest. A public interest can arise in a wide range of circumstances, including the protection of a child from harm, and the promotion of child welfare. Even where the sharing of confidential medical information is considered inappropriate, it may be proportionate for a clinician to share the fact that they have concerns about a child. [The Protection of Children in England: a Progress Report The Lord Laming 2009.](#)

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 First Response. 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 Services. Practitioners should seek to discuss any concerns with the family and, where possible, seek their agreement to making referrals to child

care services to optimise the care of 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.

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. In the process of finding out what is happening to the child, it is important to take into consideration their wishes and feelings.

Consent or the refusal to give consent to information sharing about children should always be recorded. For further information see [Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers 2018](#), 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.

Practitioners should be made aware of any protection plan around family members eg. Multi Agency Public Protection Arrangements (MAPPA), Child Protection Plans, Multi-Agency Risk Assessment Conference (MARAC), and identify the need to be involved in those processes.

In relation to Adult Safeguarding, organisations need to share safeguarding information with the right people at the right time to:

- Prevent death or serious harm
- Coordinate effective and efficient responses
- Enable early interventions to prevent the escalation of risk
- Prevent abuse and harm that may increase the need for care and support
- Maintain and improve good practice in safeguarding adults
- Reveal patterns of abuse that were previously undetected and that could identify others at risk of abuse
- Help people to access the right kind of support to reduce risk and promote wellbeing
- Help identify people who pose a risk to others and , where possible, work to reduce offending behaviour
- Reduce organisational risk and protect reputation

[Adult safeguarding: sharing information SCIE 2015](#)

Gillick Competency and Fraser Guidelines

Children and young people's views should always be sought. As children develop and mature, they will generally become more able to participate in decision-making and start to make some decisions about their own care and support even before the age of 16. Specialised legal or safeguarding advice should be sought in complex situations relating to consent and young people and information sharing.

In cases where children are considered to have the necessary maturity and understanding to make the decision in question for themselves, they are often referred to as being '[Gillick competent](#)'. Where children are Gillick competent and have the capacity to make decisions their views should be respected in the same way as an adult's request for confidentiality. This means that confidential information may only be disclosed without the child or young person's consent if this can be justified, for example, there is a legal requirement to do so or there is reasonable cause to suspect that the child or young person is suffering, or at risk of suffering, significant harm.

Mental Capacity Act 2005 (for Codes of Practice [click here](#))

All people aged 16 and over, in England and Wales, are presumed, in law, to have the capacity (ability) to make decisions in their life, unless you establish a reasonable belief that they lack the mental capacity to do so.

The two-stage functional test of capacity

In order to decide whether an individual lacks the capacity to make a particular decision, you must answer two questions:

Stage 1: Is there an impairment of or disturbance in the functioning of a person's mind or brain?

This impairment/disturbance could be anything from dementia, brain injury, learning difficulty or a mental disorder, to someone being drunk, on drugs, or having a UTI which is causing them to be confused.

When you look at the 'Diagnostic stage' (Stage 1) you should be recording what the impairment/disturbance is, how you know, when it was diagnosed, who diagnosed it.

Stage 2: Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

This is also called the 'Functional Test' and although you are not 'testing' the person, you are providing them with information and establishing a reasonable belief on the balance of probabilities that they either can, or cannot do the following: -

- **Understand** the information given to them relevant to the decision you are supporting them to make – record how you gave the information, the questions you asked and the responses you got.
- **Retain** that information long enough to be able to make that particular decision – consider how you are helping the person retain the information i.e. have they a pen and paper to take notes they can refer to?
- **Use or Weigh** the information available to make that decision (don't confuse this with Understand, part of it is seeing if the person can weigh up the pro's and con's or advantages and disadvantages of each option or of making/not making the decision.)
- **Communicate** – however they communicate, they are communicating. It doesn't matter if you can't understand what they are trying to get across or what they say has nothing to do with the decision; they are able to communicate. Really the only time you would say the person is not able to communicate is if they are unconscious or maybe if they have Locked-in Syndrome

If you have a reasonable belief that the person is unable to do **one** of these four stages then the person lacks the ability to make this particular decision.

Points to remember

- You are checking to see if the person can Understand, Retain and Use/Weigh the 'Salient' (key) points of the decision. So you need to know what these are before supporting the person to make the decision and record them on your capacity assessment
- Principle 2 of the Mental Capacity Act says that you need to take all practicable steps to enable the person to make the decision. Therefore, you need to evidence all of the steps you took ensuring that you have tried all the relevant methods without success.
- Practicable steps would also include involving family, friends, carers or other professionals, ensuring they are there in a supportive role and not answering the questions on behalf of the person in question
- If you believe the person lacks the mental capacity to make this decision then you need to record your evidence as to how you have come to that reasonable belief on the balance of probabilities.
- A person's ability to make decisions in their life can change, or fluctuate, depending on their impairment or disturbance of the mind. Therefore, you must remember that a capacity assessment is **time and decision specific**. In other words can the person make this particular decision at this particular time?

Who Assesses Capacity?

The Mental Capacity Act Code of Practice says that the decision maker is the person who is proposing to take an action in relation to the care or treatment of an adult who lacks capacity, or is contemplating making a decision on behalf of that person.

So, if you are supporting someone to make a decision within your field of expertise, then you would be the best placed individual to see if the person in question lacked mental capacity. So, for example, a GP would be assessing for capacity around medication; a Surgeon around consent to surgery; a Dentist assesses for dental treatment; an Adult Social Worker decisions around finance, care and accommodation; a Children's Social Worker decisions around a parent signing a section 20 agreement under the Children's Act.

Lack of Capacity

When a person has been assessed as lacking capacity to make a particular decision, interventions can be made in the person's best interests using the Best Interests Checklist as set out in the MCA Code of Practice (for further details [click here](#)). In urgent situations where the person lacks capacity and there is imminent, serious risk/danger to the person, an emergency application can be made to the Court of Protection.

It is worth considering that even when a person has capacity but is an Adult at Risk and there is serious risk/danger to the person, the relevant agency could approach the High Court for appropriate legal authority to intervene.

Supervision

Supervision, guidance and support from someone with knowledge of safeguarding, is essential for people working with children, parents or carers. Issues may be raised in formal structured supervision or unplanned discussions, see [Joint KBSP Integrated Supervision Good Practice Guide and Tools](#). It is crucial that all agencies establish a clear framework for supervision, guidance and support. Those supervising staff 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 substances or alcohol misuse, mental health, learning disability or other complex needs affecting parents.

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

(The Munro Review of Child Protection – Part One: A Systems Analysis, 2010)

Training

All staff working with adults, who may have parenting responsibilities, should receive child safeguarding training appropriate to their role, see [BSCB Training](#) or agencies individual training requirements.



THE THINK FAMILY PARTNERSHIP APPROACH

Everyone must think about the following questions every time they meet an individual client:

1. How are the needs and behaviour of the individual service user impacting on other members of the family?
2. Are there any children in the family? What kind of contact does the service user have with them?
3. If the service user is a parent, does he or she need support in their parenting role?
4. Is a child a young carer? What kind of care are they providing?
5. Is there an adult at risk?
6. Have the other members of the family, including vulnerable adults and children, been offered an assessment/support?
7. What can be done to help the whole family?
8. Which other services are needed to support the family?
9. Who is the Lead Practitioner? (see below)

A Multi Agency Approach

The wellbeing of children, vulnerable adults and their families is best delivered through a multi-agency approach with different services working effectively together. The following should be considered:

1. Managers will help generate family focused outcome measures. They will take account of Think Family principles and work towards more joint commissioning, allowing creative solutions to family issues which cross agency boundaries;
2. When adult and children's services are providing services to a family, practitioners will form a plan in partnership with the family, building on the family's strengths, with clear lines of accountability and regular reviews. The child's and/or adult at risk's safety and wellbeing will remain as the focus of the plan;

3. Services will value and act with reference to the views of parents, children and young people, and families will be supported in making informed choices and in shaping, developing and evaluating services;
4. Practitioners will engage with children's knowledge and expertise to validate their position in family life and acknowledge the responsibilities they may be taking. Practitioners will ask about the child's or vulnerable adult's views and feelings in developmentally appropriate language; and as a principle of good practice will try to visit at least once when the child or vulnerable adult is present. A Young Carer's assessment will be completed where necessary;
5. Parents have the primary responsibility for their children's outcomes. They also have the right to effective support to help them meet their responsibilities. Parents will be supported in their parenting in a respectful, non-stigmatising way;
6. Continued Professional development through training and supervision.

Referrals to Children's and Adults' Services

There are several ways to support families, even if you are inexperienced in dealing with some of the Think Family issues.

In the first instance, speak to your supervisor, line manager and/or designated safeguarding officer for advice; identify and record:

1. The names and ages of any children and young people in the family and their relationship to the adults in their family, whether they live with them or not;
2. The names and relationship of any vulnerable adults in the family;
3. Parenting and caring responsibilities (whether an Adult or a Young Carer);
4. Which other services for children and adults are currently involved with the family.

Discuss any concerns with the family and make a judgement about whether other services need to become involved. You will need the family's consent to make referrals to other services for children or vulnerable adults unless this places a child or vulnerable adult at increased risk of significant harm. The best interests of the child and/or vulnerable adult must be the overriding concern.

There is a list of local and national agencies at the end of this guidance.

Working Together 2018 and the role of the Lead Practitioner

[Working Together 2018](#) states that all practitioners, including those in universal services and those providing services to adults with children understand their role in identifying emerging problems and to share information with other practitioners to

support early identification and assessment. Children and families may need support from a wide range of local organisations and agencies. Where a child and family would benefit from co-ordinated support from more than one organisation or agency (e.g. education, health, housing, police) there should be an inter-agency assessment. These early help assessments should be evidence-based, be clear about the action to be taken and services to be provided and identify what help the child and family require to prevent needs escalating to a point where intervention would be needed through a statutory assessment under the Children Act 1989.

A lead practitioner should undertake the assessment, provide help to the child and family, and act as an advocate on their behalf and co-ordinate the delivery of support services. A GP, family support worker, school nurse, teacher, health visitor and/or special educational needs co-ordinator could undertake the lead practitioner role. Decisions about who should be the lead practitioner should be taken on a case-by-case basis and should be informed by the child and their family.

Troubled families

Troubled Families is a multi-agency initiative aimed at pooling the resources of key public bodies to help families with multiple and complex problems. Think Family is the approach used by the Troubled Families programme to encourage services to deal with families as a whole, rather than responding to each problem, or person, separately. The Troubled Families Team are key workers that work with the Families in Focus Team focusing on domestic violence, parenting, young people, anti-social behaviour and employment. They work closely with police, health services, job centres and schools to create intensive, tailor-made interventions. Those families have been identified via the Think Family Database through meeting two of the following six issues:

1. Parents and children involved in crime or anti-social behaviour;
2. Children not attending school regularly;
3. Children who need help;
4. Adult out of work or a risk of financial exclusion and young people at risk of worklessness;
5. Families affected by domestic violence and abuse;
6. Parents and children with a range of health problems.

The approach focuses on the root causes of issues and changes for the whole family while providing support tailored to their needs.

This involves working with families to agree a package of support best suited to their particular situation and building on family strengths. Practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities

Children's Services

When any [referral](#) is accepted by Children's Social Care an assessment will be undertaken which should be planned jointly with other involved professionals, unless

the concerns are so urgent that immediate action needs to be taken to ensure the child's safety.

Where information gathered indicates the potential risk of significant harm to the child; child protection procedures must be initiated and the assessment conducted in accordance with these procedures.

Where Children's Social Care are involved with a family where the parent or person with significant caring responsibility for children appears to have complex needs which may affect their parenting, the practitioner should discuss with the parent whether they are receiving any support from any other service and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.

If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted by the social worker in the first instance for his/her view of the family situation. Whether a referral for primary or secondary services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing, midwifery, school nurse, health visitors services are being used, they should also be involved.

If the parent is already receiving support from services, the children's services practitioner should contact the practitioner involved, and use their expertise and experience to help assess and review the parent's current and potential capacity to meet the child's needs and develop a joint agreed plan which takes into account both the parent and child's needs.

Consideration and review must also be given to new relationships forming for the parent where there are complex needs where this may present a new dynamic to home life.

Checklist for Children Services

Children's Services will, throughout their involvement with children and their families:

- 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);

- ☑ be clear whether an assessment using the Single Assessment Framework (SAF) has been undertaken and, if so, its outcomes;
- ☑ use Signs of Safety Approach;
- ☑ assess the unborn child's needs and identify desired outcomes for the child;
- ☑ assess the child's needs and identify desired outcomes for the child;

- ☑ provide a child-focused service to families with whom they are involved;
- ☑ 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 what is acceptable may be influenced by exposure to drug or alcohol abuse, or other factors (e.g. domestic abuse);
- ☑ check with other teams where parents receive services for their complex needs and particularly where there is an unborn or very young child and make sure that the assessment includes both partners, not just the mother;
- ☑ 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 for example mental health, learning disability and substance misuse team practitioners to Child Protection Conferences where they are involved with the family;
- ☑ together with relevant agencies, identify roles and responsibilities for any ongoing work with the family: a meeting is preferable where decisions need to be made and owned.

Case Management

Effective inter-agency communication and multi-agency co-operation is crucial to the management of on-going work with parents who have complex needs and their families. When practitioners receive new information that is likely to affect a previous assessment upon parenting, they must pass this information on to the other agencies involved, so that, if necessary, a reassessment of the situation can be triggered. There must also be clarity with regard to the different roles and responsibilities undertaken by different workers and a decision made regarding coordination, so that this is not left to the parent.

Child Protection Conferences

It is expected that representatives from the appropriate statutory and voluntary agencies will attend Conferences, and if they cannot, that they will provide the Conference with a written report. Representatives may also be required to attend Core Group meetings, where detailed plans to protect children are made, following the Conferences.

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.

Parents and where appropriate, children and young people, are encouraged to attend conferences however, they may be excluded 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. 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 should 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 the Child Protection Plan.

Services working with Adults

Unless it places children at increased risk, it is important to engage with and involve parents to reduce the risk of harm to children. The parent will be more likely to engage if they feel that they are not losing control of what happens next.

Services working with adults will, throughout their involvement:

- identify at an early stage any children within families and specifically those with a caring responsibility;
- ensure, when assessing adults' needs, that any support to help their parenting role is taken into account;
- retain a family focus, ensuring that they are not focusing solely on the adult, making the children 'invisible';
- understand that although parental mental ill-health, learning disability or drug and alcohol problems, 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 Services or other services to multi-professional care planning meetings where they are involved with the family, with the agreement of the service user;
- provide a representative to attend Child Protection Conferences where at all possible or at the very least, provide a report;
- ensure they are kept informed about plans for any children and incorporate these into future care planning.

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, a referral should be made to Children's Services (social care) in order that the appropriate action can be taken. These concerns may include:

- failure to attend for appointments;
- failure to allow access for home visits;
- avoidance of practitioners;
- homelessness or family network breakdown;

- deterioration in mental health, physical health, more chaotic drug and alcohol usage;
- introduction of a new adult, child or young person into the home situation;
- change of circumstances which may impact on risk or resilience. Please refer to the Threshold Document for guidance.

Referrals to Adult Services Health and Social Care

Discussions and referrals

If you want to discuss care and support for adults with possible care and support needs or make a referral you can contact Care Direct. If there is uncertainty about whether an adult meets the eligibility threshold for Adult Social Care, please contact

Ring Care Direct - 0117 922 2700 or make a referral with their [online referral form](#)

Safeguarding concerns

If there are concerns about immediate neglect or harm to a vulnerable adult (who is vulnerable due to age, frailty, mental health, physical disability, ill health, learning disability, dementia, alcohol or substance misuse), then contact Direct immediately on the phone number and follow the local Safeguarding Adults procedures and if urgent call 999.

Ring Care Direct - 0117 922 2700

Professional advice and consultation

If, rather than making a referral, you want to seek professional advice and consultation regarding support and care for an adult with possible health and social care needs you can also contact Care Direct.

Ring Care Direct - 0117 922 2700

Accessing community health services

Intermediate care within Bristol includes a range of services that Bristol Community Health provides in partnership with Bristol City Council's Health and Social Care Team. Intermediate care includes rapid response, community rehabilitation and reablement, residential centres, and hospital based teams. Rapid Response, who offer care for those who are suffering from acute episodes of illness visit patients in their own home or place of residence for up to 7 days. They also have hospital based teams that provide a link with Intermediate Care Services in the community and help to facilitate the discharge of patients from hospital care.

[Rapid Response Referrals](#)

To refer call the **Single Point of Access (SPA)** on **0117 903 0202**. This telephone line is open 24 hours a day, 7 days a week.

Accessing the Primary Care Liaison Service(PCLS) for mental health

[Primary Care Liason Service for Mental Health](#) is essentially accessible to professionals or referrals can go via the GP. SPA can send secure emails or make telephone referrals to PCLS.

Contact details can be found [here](#).

Child Care issues

Consideration should be made to child care issues including for parents to access treatment, especially in school holidays to ensure there are no barriers to treatment and that the child's needs are also being met.

Professionals should consider:

- whether the parent needs childcare support to access treatment;
- what childcare arrangements need to be in place for the parents to access inpatient or residential rehab;
- who is offering the child support;
- whether the patient needs support getting the child to and from nursery or school;
- what the child's understanding is of the parents treatment;
- whether the parent needs support in explaining what is happening;
- whether a referral to a young carer's service needs to be considered.

Specific Guidance

Young Carers

“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 impact on his or her emotional or physical well-being or educational achievement and life chances.”

(ADASS/ADCS MOU 2012)

Many young carers value their caring roles and are often proud of the contribution they are able to make in their families. All too often, however, children and young people become carers because someone in their family has significant unmet care needs arising from ill health, disability, mental health needs or substance misuse. In some cases young carers have taken responsibility, sometimes assuming a level of responsibility that no child should be expected to take on. This can have consequent knock-on effects on schooling and other key areas of their lives.

Young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring states that services should adopt a “whole family approach” [The Young Carers’\(Needs Assessment\) Regulations 2015](#). This means that children’s and adult services must have arrangements in place to ensure that no young person’s life is unnecessarily restricted because they are providing significant care to an adult with an identifiable community care need”. For services to provide effective support for young carers and their families, it is vital that all members of staff 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.

For advice and support for carers in Bristol telephone 0117 965 220 or visit: www.carerssupportcentre.org.uk.

You can contact the Carers Support Centre using their [online form](#). Parental mental health

The Children Act 2004 identifies children whose parents suffer from mental illness as one of the key groups of vulnerable parents, who need to be targeted in order to provide appropriate support for parenting when it is required.

In the [Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014](#), approximately 1 in 6 adults in England reported met the criteria for a common mental disorder (CMD) in 2014. Women were more likely than men to have reported CMD symptoms. One in five women (19 per cent) had reported CMD symptoms, compared with one in eight men (12 per cent). Women were also more likely than men to report severe symptoms of CMD - 10 per cent of women surveyed reported severe symptoms compared to 6 per cent of men.

This guidance 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 workers 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.

Living in a household where parents or carers have mental health problems doesn't mean a child will experience abuse or negative consequences. Most parents are able to give their children safe and loving care and many children go on to achieve their full potential in life, particularly if their parents receive the right support at the right time ([Hogg, 2013](#)). However, mental health problems are frequently present in cases of child abuse or neglect. An analysis of 175 serious case reviews from 2011-14 found that 53% of cases featured parental mental health problems ([Sidebotham, 2016](#)).

Parental Mental health can result in children experiencing abuse, in particular emotional abuse and neglect. Mothers who experience mental ill health after birth may struggle to provide their babies with the sensitive, responsive care essential to their social, emotional and intellectual development. Family members can be reluctant to discuss mental illness with each other. Lack of communication can result in misunderstandings and children may feel worried or alone. They may not understand that their parent or carer's withdrawn behaviour is a symptom of mental illness. Gatsou et al (2017) stated they may feel responsible for their illness and obliged to try and fix it.⁵

Parents and carers with mental health problems may:

- experience inappropriate or intense anger or difficulties controlling their anger around their children;
- have rapid or extreme mood swings, leaving children frightened, confused and hyper-vigilant;
- be withdrawn, apathetic and emotionally unavailable to their children. They may have trouble recognising children's needs and responding to cues;
- view their children as a source of comfort and solace, which may lead to children taking on too much responsibility for their age;
- have distorted views of their children for example, they may believe a child is to blame for their problems or a child has behavioural problems when there is no evidence for this;
- struggle with keeping to routines such as mealtimes, bedtimes and taking their children to school;
- neglect basic standards of hygiene and their own and their children's physical needs
- fail to seek medical care for their children;
- struggle to keep their homes clean, buy food and clothes and pay essential household bills;
- struggle to set boundaries, discipline and supervise their children, which could leave them in unsafe situations;
- In rare cases of severe mental illness, parents and carers may have delusions related to their children, for example they may believe they are possessed, have special powers or are medically unwell.

([Cleaver et al, 2011](#); [Hogg, 2013](#))

⁵ Gatsou, L. et al. (2017) The challenges presented by parental mental illness and the potential of a whole-family intervention to improve outcomes for families. *Child and family social work*, 22(1): 388-397.

Parents and carers with mental health problems may go through other stressful life experiences like:

- divorce or separation;
- unemployment;
- financial hardship;
- poor housing;
- discrimination;
- a lack of social support.

Assessing the risk of parental mental health problems

There may be some family factors which increase the risks to children. There may also be other factors which protect children or reduce the impact of their parents' problems.

The [NSPCC](#) has compiled a list (non exhaustive) of the factors to consider when assessing risk. They are;

- the risk of harm to children increases when they're exposed to a number of problems at the same time or over a period of time. A thorough assessment of potential risks should be conducted if a family is experiencing [domestic abuse](#) or [drug and alcohol problems](#) alongside mental health difficulties;
- related stresses such as poverty, poor housing, family separation and lack of social support can also increase the risk of children suffering harm;
- young children rely on their parents and carers to give them the warm, nurturing care they need for healthy development. Children are most at risk of harm when their mother's mental health problems begin in pregnancy or the first year of life, especially if they are long-lasting or severe;
- teenagers also need strong parental guidance and support as they transition to adulthood;
- the stresses of parenting can make it even more difficult for a parent or carer to cope and this may impact on a child's welfare;
- always consider the severity of a parent or carer's mental health symptoms. If they are making threats to harm themselves, their children or other family members, or if they appear to be suffering from psychotic delusions, this should always trigger a thorough assessment of risks to the children's safety;
- if a parent or carer isn't accepting support offered by mental health services or attending appointments, this loss or lack of support may impact on their children's wellbeing or safety;
- children may be more at risk of harm if the parent or carer experiencing difficulties is living alone with them without the support of another adult;
- consider if any of the children had to take on caring responsibilities for their parent, carers or siblings.

Furthermore they state that risks to children's safety may be reduced by a number of protective factors, including:

- parents and carers who are willing to acknowledge their difficulties and accept support from services;

- friends or relatives who are able to care for children and help with household chores when needed;
- sufficient income support, benefits and advice available to families struggling with unemployment and poor housing;
- if children are regularly attending school or nursery the family will be able to receive additional support from education professionals who can also monitor their situation;
- children who have developed a range of approaches for solving problems and know how to ask for help in the event of a crisis with their parent;
- good facilities in the wider community such as young carers' projects.

Psychosis

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:

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

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 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.

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 First Response(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 an immediate referral to First Response (social care).

It is important that if a practitioner feels that a person may be a 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 2007, if they believe the person to be a risk to themselves and/or others.

Any changes to medication should be seen as an increased risk factor therefore a period of monitoring may be required to assess if any changes in behaviour may increase the risk to a child(ren) or any other person.

Whole Family Approach to Parental Mental Health

The NSPCC captures why a whole family approach is necessary and states that;

- Parental mental health problems affect everybody in the family. Evidence suggests successful interventions involve a whole-family approach which address a parent's mental ill health in the context of each family member's needs and experiences and co-ordinates support from adult and children's services ([Cleaver et al, 2011](#); [Gatsou et al, 2017](#); [Grove et al, 2015](#)).
- Interventions which encourage families to communicate with each other can help everyone to understand the impact of the mental health problems ([Grove et al, 2015](#)). Supportive conversations between family members can help children feel less worried and isolated. They can also help parents and carers understand their children's experiences which may have a more positive effect on parenting ([Coates et al, 2017](#)).
- Whole family interventions can offer practical support. For example, helping family members to design and implement 'staying well' plans for the parent with mental health problems. This could include sign-posting to other services, setting goals, developing problem solving skills and offering advice on managing stress and recognising the early signs of a relapse ([Gatsou et al, 2017](#)).
- Evidence suggests that family-sensitive practice has a number of benefits including better relationships between family members, an increase in family members' levels of self-confidence and self-esteem and greater willingness to ask for help and support when needed ([Gatsou et al, 2017](#)).

Screening questions

Any assessment should measure the potential or actual impact of mental health on parenting, the parent/child relationship and the child as well as the impact of parenting on the adult's mental health. Screening questions¹² could include:

- On a scale of 0-10 (with 0 meaning 'not at all worried' and 10 meaning 'very worried'), how would the individual assess their mental health and emotional wellbeing?
- Is the parent accessing mental health services (starting with the GP)?
- Does the parent need support in their parenting role?
- Are there any children in the household?
- How does the parent's mental health impact on the children?
- What happens to the children if the parent is unable to care for them (i.e. is there a safety plan)?
- Is there a child in this family providing care (ie is the child a Young Carer)?

- Is anyone providing support for the children?

Perinatal Mental Health

The Perinatal Period includes pregnancy and the year following birth. During this period women can be affected by a whole range of mental health problems ([Joint KBSP Multi-Agency Protocol](#)). These can range from mild anxiety such as panic attacks through to depression and sometimes severe mental illness after child birth such as Postpartum Psychosis (Puerperal Psychosis). All conditions can be prevented, treated or managed.

Mental illness can have a devastating effect on woman and their families. Effective and timely detection, intervention and support can prevent and minimise the harm that can be done. Illnesses such as this can be diverse and complex. A good understanding of the signs, symptoms, effects and consequences that mental health can have is vital. It is important to mitigate the effects it can have on the woman and their family and improve the wellbeing of children and their health. This is every professional's responsibility and requires a well-defined coordinated Multi-Agency response.

Women that experience mental health issues in the perinatal period can often have no history of mental illness. Any women regardless of socio economic status can be affected. Others with pre-existing issues could experience a deterioration or reoccurrence of past health issues as a result of the changes to the woman's body emotionally and physically or because of a change in medication.

Mental Illness during pregnancy, birth and the postpartum period can present itself in many different ways, each with their own symptoms but all requiring some form of support or intervention.

Women who are not currently experiencing mental health issues will receive support from universal services such as Midwives and Health Visitors through the universal visiting patterns outlined in their local procedures. These Universal Services are key in the early identification of mental health issues and signposting to the appropriate support (NSPCC 2013).⁶ Should a woman be identified as requiring additional support, for example expressing symptoms of mild depression and/or anxiety then additional support could be offered at a Level 1 Plus level by Health Visiting services, and Midwifery services. Alternatively, GPs can support women who have been identified by the Midwife or Health Visitor as needing additional support. Women can also self-refer to their GP for support. GPs can treat uncomplicated non-psychotic depression and anxiety. This may include prescribing medication or signposting to more specialist services. It is important for GPs and mental health workers to be aware of the potential risks associated with mental health needs.

GPs can refer women to Bristol Wellbeing therapies for further support, for example for educational courses on self-help and one-to-one therapies. The individual would also be able to self-refer to the wellbeing service. This service is designed to support

⁶ NSPCC, 2013. Prevention in mind, All Babies Count: Spotlight on Perinatal Mental Health. Available from: <https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf>

individuals with mild to moderate depression and anxiety using a Cognitive Behavioural Model of therapy. Other self-help provision and charitable organisations are available for the individual to access. For example Mother's for Mother's and Bluebell Care (Bristol) service provides resources about common mental health issues during the perinatal period, amongst other support services such as groups and the 'Buddy Service' for 1:1 face to face support. If more specialist support and advice be required then GPs should refer to secondary mental health services for more complex or significant disorders. This specialist support can take three forms:

1. The Specialist Perinatal Mental Health service can provide advice to the GP and or Midwifery service, with the GP and midwife remaining the lead professionals;
2. Should the individual already be under Secondary Mental Health services then the Secondary Mental Health team continues leading on the mental health care provision whilst being supported by the specialist Perinatal Mental Health Team ,as an adjunctive service, on areas where perinatal expertise are required to manage the individual's care;
3. should the individual referred not be open to secondary mental health services, and meet the threshold for high risk mental health need (see attached care pathways) then the Specialist Perinatal Mental Health Team would coordinate care under non-CPA where the perinatal psychiatric illness is the primary need. Should the mental health concerns pre-date pregnancy or be expected to continue beyond perinatal period, referral to Recovery teams may ensue.

Red flag signs/activators

It is important for practitioners working with women within the perinatal period to be aware of '**red flag**' signs/ '**activators**' for action. These signs are indicative of severe maternal mental illness and require urgent assessment:

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant

(MBRRACE-UK 2015)⁷

Should there be concerns around potential or actual risks to the unborn baby, practitioners are advised to follow recommendations set out in the Expected Baby Policy. Concerns relating to the unborn baby must be referred to First Response as soon as possible following the 12th week of pregnancy ([The Expected Baby Protocol](#))

An additional consideration is that of concealed pregnancy ([Concealed Pregnancy Protocol](#)).

⁷ <https://www.npeu.ox.ac.uk/downloads/files/mbrance-uk/reports/MBRRACEUK%20Maternal%20Report%202015.pdf>

Concealed pregnancy is when:

- An expectant mother knows she is pregnant but does not tell any professional; or
- An expectant mother tells another professional but conceals the fact that she is not accessing antenatal care; or
- A pregnant woman tells another person or persons and they conceal the fact from all health agencies.

Whole Family approach to Perinatal Ill health

All services working with mothers affected by perinatal mental illness must ensure that they engage, support and work with their partners and other key family members. Perinatal mental illnesses can have a significant impact on the families of women who are affected. Family members are also important sources of support for the mother, and can mitigate the effect of her illness on the baby. Therefore it is important that mental health services 'think family'. These services must also have processes in place to identify fathers who are suffering from mental illness themselves and ensure they have access to additional support.

Local Contacts

Bristol GPs

[Bristol Wellbeing Therapies](#) follows a stepped care approach. There are five steps of psychological treatment within Bristol Mental Health. Bristol Wellbeing therapies offers treatments that sit within either step 2 or step 3. If at assessment they feel that treatment offered is needed at a higher step they refer on appropriately.

[Primary Care Liaison Service](#) is the initial point of contact for mental health services within AWP (Avon and Wiltshire Partnership NHS trust) for Primary Care and other agencies. The Primary Care Liaison Service provides advice and support to primary care, as well as specialist mental health assessments, working closely with a range of other teams such as the adult Support and Recovery Team, older adult Complex Intervention Team, Intensive (previously Crisis) Team, Memory Services, Drug and Alcohol, and Eating Disorder Services.

Community perinatal mental health service will offer advice to all professionals. To contact them e mail awp.perinatalmentalhealthservice@nhs.net Telephone 0117 919 5826

Bluebell –Support for Women and families.

Offering a variety of free, weekly activities designed to help parents manage feelings of anxiety and depression related to pregnancy and birth with group programmes including therapeutic, creative and pampering sessions with an occupational therapist and a Buddy worker including Dad's support line.

<http://www.bluebellcare.org/>

Tel 0117 922 0746

Dads' support line: Tel no. 07730 367 483

Bristol Sanctuary - Bristol Sanctuary is a place which feels safe, comfortable and welcoming, where people who are experiencing severe emotional distress can go for help outside of normal working hours.

<http://www.bristolmentalhealth.org/services/bristol-sanctuary/>

Tel 0117 954 2952

National Contacts

Anti-bullying Alliance

Includes sections for children, parents and professionals

<http://www.antibullyingalliance.org.uk/>

Childhood Bereavement Network

A national, multi-professional federation of organisations and individuals working with bereaved children and young people

<http://www.childhoodbereavementnetwork.org.uk/>

Childline

Helpline offering counselling for children and young people, as well as publications and campaigns for professionals and carers <http://www.childline.org.uk/>

Eating Disorders Association - BEAT

Information and help on all aspects of eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder and related eating disorders <https://www.beat.co.uk/>

Family Lives (formerly Parentline Plus)

Family Lives is a listening, non-judgemental service which supports families with difficulties and challenges and supports happier family relationships and stronger communities. Tel **0808 800 2222** <http://www.familylives.org.uk>

Mental Health Foundation

UK charity for everyone's mental health, provides information and resources about mental health including people with learning disabilities

<http://www.mentalhealth.org.uk/>

MIND

Resources, training and campaigning on mental health issues, plus local groups

<http://www.mind.org.uk/>

Need2know

Website for young people with a wide range of health related information including mental health issues such as bullying, relationships and more

<http://www.need2know.co.uk/>

Nurture Group Network

A national charity promoting nurture groups and supporting the professionals who work in them, providing information on research, evaluation and resources

www.nurturegroups.org/

Promoting Children's Mental Health

DfE (2016) Mental health and behaviour in schools

<https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2>

DfE (2016) Counselling in schools

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497825/Counselling_in_schools.pdf

PSHE Association (2015) Guidance on preparing to teach about mental health and emotional wellbeing

<https://www.pshe-association.org.uk/curriculum-and-resources/resources/guidance-preparing-teach-about-mental-health-and>

DfE (2015) Promoting the health and wellbeing of looked after children

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

Royal College of Psychiatrists

Offers an information service and leaflets on common mental health issues including difficulties in adolescence <http://www.rcpsych.ac.uk/expertadvice/youthinfo.aspx>

Samaritans

Helpline open 24/7, 365 days per year. You do not need to be suicidal. Free telephone helpline: **Tel. 116 123.** www.samaritans.org

SANE

Charity which works to improve the quality of life for anyone affected by mental illness www.sane.org.uk

Self Harm

For young people who self harm and their friends, family and professionals. Be aware that this site contains sensitive information <http://www.selfharm.org.uk/>

Teenage Health Freak

Information and advice on health issues for young people, including dealing with stress plus answers to common questions <http://teenagehealthfreak.org>.

The Hideout - Women's Aid site for Children and Young People

Help, information and support for children and young people - whether they are currently living with domestic violence, have experienced violence in the past or know someone else going through it and are looking for help and information <http://www.thehideout.org.uk/>

Time to Change

Time to Change is England's biggest programme to challenge mental health stigma and discrimination <http://www.time-to-change.org.uk/>

Winston's Wish

Winston's Wish offers practical support and guidance to families, professionals and anyone concerned about a grieving child. Giving the right support at the right time can enable young people to live with their grief and rebuild positive futures <http://www.winstonswish.org.uk/>

The Mix

Free, confidential website for young people under 25 <http://www.themix.org.uk/mental-health>

Hope Again

Youth website of Cruse Bereavement Care <http://hopeagain.org.uk/>

Young Minds

Resources and training to improve children and young people's mental health.

Parents' free telephone helpline: Monday - Friday 9.30am – 4.00pm

Tel. 0808 802 5544 <http://www.youngminds.org.uk/>

Alcohol and Drug problems

Whilst there may be different treatment methodologies for adults with alcohol and drug problems, they are considered together because the consequences for the child are quite similar. Drug problems refers to illicit drugs, alcohol, prescription drugs and solvents, the consumption of which is either dependent use, or use associated with having harmful effect on the individual or the community.

Drug and alcohol treatment providers should ask all service users who have a child living with them (or who may live with them in the future) a standard set of questions to ensure an appropriate data set is collected in relation to safeguarding.

This section should be read in conjunction with:

[**BSCB Protocol to Prevent Childhood Exposure to Opioid Substitution Medication**](#) to assist professionals to identify which patients are parents or carers,

those that have children or children staying with them and the safeguarding arrangements that should be in place when a parent is undertaking Opioid Substitution Treatment;

BSCB/Safer Bristol Joint Practice Guidance for Children's Services and Adult Substance Misuse Services.

Harm reduction information to parents

All parents in treatment should receive harm reduction information in relation to their parenting. This should involve a strengths-based discussion as well as written information around a number of risky lifestyle areas, such as the impact of substance misuse on children and the family, protective factors for children, storage of medication, safe storage and disposal of needles, and what to expect from drug and alcohol treatment services working in collaboration with children services.

Although drug and alcohol use in itself does not necessarily affect parenting, the behaviours associated with it may have a detrimental effect on the welfare of children. By reducing the impact of parental substance misuse on children, risks to them can be reduced. Kinship carers (such as an involved grandparent) may be a protective factor, and it is good practice to consider their support needs in any assessment.

If service users do not have children of their own but live with someone else's children or have contact with, but do not live with, their own children, this information should still be collected in relation to the child(ren) in question and appropriate information and services offered. Whether or not the service user currently has children, they should be asked if they or their partner are pregnant. Women may be unaware of the health risks associated with drinking during pregnancy and this should be discussed along with the possible harmful effects on the foetus. Fetal alcohol spectrum disorders (FASD) is an umbrella term for several diagnoses related to prenatal exposure to alcohol. For substance misusing women in pregnancy and their partners and family alcohol screening in antenatal services maybe considered together with other [specialist interventions](#), such a Bristol Specialist Drugs Project (BSDAS), Specialist Midwives and family nurse partnerships (FNPs).

Pregnancy can provide significant motivation to change, which treatment providers will be in a position to maximise. Early access to antenatal care and joint care planning could reduce the risk to unborn children.

Undertaking assessments

Where there is no current children and families services involvement, treatment provider staff will need to assess the parenting needs of the service user. This is likely to be based on the parent's view, as the child may not be seen by the drug and alcohol worker. Caution must be taken as there is a tendency for professionals to over-rely on parental information without triangulating against other evidence. As part of the assessment, it is good practice to gather information about other services working with the family and arrange a joint home visit with another professional – a joint approach to visiting is safer for professionals.

There are a number of benefits to this, including:

- a better understanding of the child's environment;
- the ability to identify and act on high-risk environmental factors, such as fire safety hazards and safer drugs and paraphernalia storage;
- insight into the interaction between parent and child at home;
- the opportunity to identify young carers;
- enabling partner and family members to receive information and support directly, particularly about what to expect from drug and alcohol treatment;
- encouraging the development of a supportive relationship with the family;
- providing an opportunity to listen to and record any comments made by children during the visit

Consideration could also be given to wider factors impacting on the family, for example housing and accommodation, finance, employment, mental health and domestic violence, as there is commonly a relationship between these issues in families with additional support needs.

All drug and alcohol treatment services should ensure that adult assessments consider the need for early intervention and support for parents and children. The majority of substance misusing parents presenting to treatment services are likely to have some form of parenting support needs, so an understanding of the range of services available to this group is essential.

Implication for and effects on Parenting

Excessive drug or alcohol use by parents/carers does not, on its own, automatically mean that children are at risk of abuse or neglect, but 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. 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.

The following situations relating to a child or children 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

- Keeping a child at home to provide care
- Family income used for drug/alcohol purchase rather than basic essentials
- 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 either in or outside the home
- Domestic abuse
- Disruption to relationships with the extended family, reducing the protective factor for children

Supporting Parents and Children – Factors to Consider

1. Does the parent need childcare support to access treatment?
2. What care arrangements need to be in place for the parent to access hospital, a detox/rehab unit or home detox?
3. Who is offering the child support?
4. Does the adult's crisis or contingency plan include a plan for care of the child?
5. Will the parent need support getting the child to and from nursery/school?
6. Is there any liaison with school or early years' service?
7. What is the child's understanding of the parent's treatment, does the parent need support in explaining what will happen?
8. Consider a referral to the Young Carers' service for the child carer
9. Make a referral to Children's Services (Social Care) if you consider the child may be at risk of harm.
10. Make a referral to Children's Services (Social Care) if a child is likely to be cared for outside their immediate family for more than 28 days (private fostering).

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.

Referrals to children and family services

It is good practice for the service manager and/or safeguarding lead to review information gathered during the assessment and throughout treatment, and monitor the need for onward referral either to universal children and family services or to children's social care. Substance misuse professionals should be clear about the kind of referral they may need to make, with all staff trained around thresholds.

Issues for a practitioner to consider when assessing parental substance use

Do not ignore substance use

As a matter of routine, all child protection assessments should consider whether substance misuse is a contributory factor. Open questions such as *“Can you tell me about your use of alcohol and drugs?”* are more likely to prompt discussion than closed questions such as *“Do you use illegal drugs?”*

Use pre-birth assessments

These can provide a valuable opportunity to engage expectant parents, who are often very highly motivated to make changes in their lives. Exposure to drugs during pregnancy may have had an effect on the child’s health before and after birth. Has the mother attended ante-natal appointments and followed the advice to reduce the potential risk to the baby? Bristol Children and Young People’s Services “Expected Baby Protocol” states: “a pre-birth core assessment should always be carried out where there are significant concerns about drug or alcohol misuse and/or a history of previous child protection concerns”. Foetal alcohol syndrome is a concern where expectant mothers drink.

Remember that substance users want to be good parents

Be aware that their aspirations may be too high: that expectant parents may want the child to compensate for past unhappiness or provide an incentive to remain substance free. They may set themselves unrealistic goals. The process is similar to couples in failing relationships having children in the hope that it will bring them together again. Any expectation that a baby will make things better is flawed; the stress of caring for a baby may increase drug/alcohol consumption. It may lead to attempts to become abstinent too rapidly, with considerable risk of relapse. Detoxification whilst pregnant requires specialist interventions.

Consider the importance of substance use in the parent’s life

If a parent’s primary relationship is with a drug or alcohol, then it will adversely affect their relationship with others including children. If household resources - financial, practical and emotional - are diverted to substance use, there will be deficits for the children.

Ask for details of the drug and alcohol use and their effects

“Drug use” or “Drinking” are not single phenomena but include a wide range of behaviours. The parent, who consistently drives under the influence with their child in the car, may be seen very differently to a parent leaving a ten year old in charge of the home whilst going out to buy drugs. This in turn could be viewed differently to being physically present but incapable through intoxication. There is no easy scale. Specific information about the nature of substances used, and the lifestyle implications of such use, is needed in order to assess the impact on parenting. Note that use of one substance does not preclude others: a range of illicit drugs, prescribed medication and alcohol. Also being in receipt of a prescription (e.g. methadone etc.) does not always lead to stability or exclude use of other substances. Substance users are experts in their own substance use: if in doubt ask them to explain. Risk assessment tools specific to alcohol misuse and drug misuse

are provided in the appendices to aid practitioners in determining the impact of a parent's drug and/or alcohol use.

Do not assume that abstinence will always improve parenting skills

Substance use may serve a function as an emotional or psychological support. There may be risks of relapse, or parents may struggle to adjust to a substance-free lifestyle or relationship. Where applicable, stability in treatment might be a more realistic option.

Find out whether substance use is the “only” parental problem

If so, then prospects for success are higher. Substance users face the same challenges as the rest of the population. Substance misuse makes all other problems worse. Where there are multiple parental problems (e.g. mental health difficulties, domestic violence), then prospects of being able to offer safe and long-term care to children are significantly reduced.

Consider age-related risks

A child born to a drug or alcohol-dependent mother may need to be followed up to monitor any special health/developmental needs. It is important to consider these needs and the parent's ability to meet them. Substances and drug-using paraphernalia are a potentially serious hazard to young children. A number of very young children are admitted to hospital and sometimes die each year from ingesting their parent's methadone. 'Children of substance misusers are in more danger of inadvertently ingesting drugs because these substances are present in the home; methadone and cocaine are extremely dangerous to children⁸. It is therefore important to establish the following information:

- what substances are being taken?
- are needles used?
- where everything is stored and are they locked away securely?
- are the children aware of where the substances are kept?

At the older end of the age spectrum:

- are any of the child's siblings using substances? (This may also increase the likelihood that the child will themselves become involved in substance use);
- what is the child's role?
- are they being cared for or have they become carers for siblings and/or parents?
- what are their hopes and fears?
- who can they turn to?
- how does the child relate to other children?
- do they have friends outside a drinking/drug-using subculture?

Children may be inhibited from developing relationships with other children or embarrassed by their parent's behaviour. Friendships can provide vital support and a source of sanctuary from problems at home.

Base your judgements on evidence not optimism

⁸ P 117, Barnard. M (2007) Drug addiction and families. London: Jessica Kingsley pub

If substance use is enduring and chaotic and there is no evidence of improvement, this will undermine other interventions or support offered. It is better to be realistic from the onset. Creating plans and agreements that are unrealistic promotes a sense of failure in the parent and may put the child at risk. Setting new contracts in the hope of improvement is not appropriate.

Be aware of your own views and feelings about substance use

Consider how these might affect your judgements. If you are unfamiliar with drug use and users, it may help to think how you would respond to an alcohol user or a smoker trying to change their behaviour. Assessments must be based on evidence.

Recognise that parents are likely to be anxious

Drug users in particular will worry about losing their children. This “fear factor” is likely to lead to reluctance to seek help or a denial or minimisation of problems. Children may share this fear of being separated from their parents.

Include family members

Include fathers, partners and relevant members of the extended family (for example grandparents). Assessment can sometimes focus on mothers, but others may have an equal impact on the children. Where extended family members are described as significant support by parents ensure that you are aware of what that support is and whether there are any difficulties (e.g. substance misuse, mental health issues etc.) that may affect the support they can provide. Family group conferences may make a real contribution to decision making.

Explore the child’s point of view

What is the reality of home life? i.e. What is a day in the life of the child like? Do the parents thoughts about this match or vary those of the child?).

Local Contacts

Bristol Recovery Orientated Alcohol and Drugs Service (ROADS)

This is part of the Bristol wide service to support anyone directly or indirectly affected by the problems associated with drug and alcohol misuse.

Support will include the following:

Extra and more flexible treatment to support people to focus on recovering from their dependency on drugs or alcohol.

- A programme of support to stop people from relapsing including group work and access to an online support programme called Breaking Free Online.
- A range of housing support will be provided for different stages of their recovery.

- Opportunities for people to get work experience, including volunteering opportunities and access to training and education.
- A range of support for families of people with drug and alcohol problems.
- Access to a range of mutual aid options/self-help groups, including SMART and 12 Step Fellowships.
- The service will be committed to meeting the needs of a diverse community.

Email: roads@dhi-services.org.uk

Telephone: 0117 440 0540 (DHI)

Open Monday to Friday: 9am to 8pm

There are drop in sessions for service users at the local Community Recovery Hub

Community Recovery Hub times and locations

Drop in Monday to Friday: 1pm to 3pm (closed bank holidays)

- Central: E5, 16-18 King Square, BS2 8AZ
- North: Greenrooms, Greenway Centre, Doncaster Road, Southmead, Bristol, BS10 5PY
- South: @Symes Community Centre, Peterson Avenue, Hartcliffe, Bristol, BS13 0BE

Alternatively, professional looking to support someone to access ROADS services, you can fill in the [ROADS Engagement Referral Form \(pdf, 104k\) \(opens new window\)](#) and email it to DHI.

If you are a GP, please access the [online REMEDY Referral Support Tool](#) for clinical pathways and guidelines.

Email: roads@dhi-online.org.uk.cjism.net

Telephone: 0117 440 0540 (DHI)

Open:

Monday to Friday: 9am to 8pm

Saturday: 9am to 1pm

Bristol Drugs Project (BDP)

For treatment and engagement service.

Call 0117 987 6000 Email info@bdp.org.uk

Visit <http://www.bdp.org.uk>

Available Monday to Friday 9.00 am to 8.00 pm and Saturday 10.00 am to 5.00 pm.

11 Brunswick Square, BS2 8PE

Addiction Recovery Agency - Kings Court, King Street, Bristol, BS1 4EF

Housing services for people at all stages of recovery.

Call 0117 930 0282

Email info@addictionrecovery.org.uk

<http://www.addictionrecovery.org.uk>

Avon and Wiltshire (NHS) Mental Health Partnership Trust (AWP)

For specialist community and inpatient treatment for drugs and alcohol, including stabilisation and detoxification. Referrals through ROADS Engagement Service. Priority appointments for the most complex clients.

Call 0117 9232077

Email – Visit - <http://www.awp.nhs.uk/services/sdas>

Detox in a GP Practice

Support in alcohol detox or an opioid substitute prescription and detox. BDP's Shared Care team work in GP Practices across Bristol.

GP can make a referral or contact ROADS for more information.

Homelessness and Housing

A range of supported housing opportunities are available to match stages in the recovery journey.

Housing support for alcohol and drugs is led by ARA (Addiction Recovery Agency). Professionals can refer via the [Housing Support Register](#).

Email: info@addictionrecovery.org.uk

Telephone: 0117 930 0282 (ARA)

St Mungos's Housing

Housing, Health and skills support across Bristol. Call 0117 9440581 Email info@mungos.org

Visit <http://www.mungos.org>

Alcoholics Anonymous Call 0845 769 7555 Email help@alcoholics-anonymous.org.uk

Website <http://www.alcoholics-anonymous.org.uk/>

Cocaine Anonymous

Cocaine Anonymous is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from their addiction.

Call 0800 612 0225 Email wtf@cauk.org.uk

Visit <http://www.cauk.org.uk/index.asp>

Frank

Call 0300 123 6600 Email frank@talktofrank.com

Visit <http://www.talktofrank.com/>

Narcotics Anonymous

For people needing support and advice about the nature of drug addiction. Anyone from the using addict, their friends and family members through to drug workers and the press are welcome to call.

Call 0300 999 1212 Email fsmail@na.org Visit <http://www.na.org/>

Samaritans

Call 08457 90 90 90

Email jo@samaritans.org

Visit <http://www.samaritans.org/>

Shelter

Call 0808 800 4444 Email info@shelter.org.uk.

Visit <http://england.shelter.org.uk/>

Parents with a Disability

There are around 1.7 million disabled parents in the UK, mostly with physical and sensory impairments.⁹

Health and social services have a legal duty under the Disability Discrimination Act 2005 to make reasonable adjustments to ensure their services and any information are accessible to disabled people with disabilities.

Early intervention improves outcomes. Parents with a disability can improve their parenting skills with additional support tailored to their needs. For example childcare skills can be taught through behavioural modelling, using visual manuals and audiotaped instructions, and using simple behavioural instructions. Parents learn more effectively where they are given praise and feedback, and where complex tasks are broken down into simpler parts.

Equal opportunities

Research shows that assessments are sometimes influenced by stereotypes about the capacity of parents with a learning disability to parent. When approaching any assessment it is important to be reminded that:

“People with learning disability have the same rights and are entitled to the same expectations and choices as everyone else, regardless of the extent or nature of the disability, their gender and ethnicity; and, ”¹⁰

“Parents with learning disability can in many cases be supported by family and supportive networks and professionals, enabling them to respond effectively to the needs of their children. ”¹¹

⁹ <https://www.bestbeginnings.org.uk/parents-with-disabilities>

¹⁰ Chapter 18 as above

¹¹ DOH (2000) Framework for the Assessment of Children in Need and their Families; Good Practice Guidance.

Professionals should bear in mind the implications of the Human Rights Act 1998 and guard against treating parents with a Disability less favourably than others.

Parents with 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.

The ability of parents with a disability and in particular those with a learning disability need to provide a reasonable standard of care, this will depend on their own individual abilities, circumstances and the individual needs of the child.

The issues which most frequently give rise to concern in relation to parents with disabilities arise from a lack of skills, understanding or knowledge of the child's needs, rather than deliberate abuse. Consequently learning disabled parents may need considerable support to develop the understanding, resources, skills and experience to meet the needs of their child.

Such support is particularly important if they also experience additional stressors e.g. having a disabled child, domestic abuse, poor physical or mental health, substance misuse, social isolation, poor housing, poverty or a history of growing up in care.

Children of parents with learning disabilities are at increased risk from inherited learning disability and more vulnerable to psychiatric disorders and behavioural problems.

Such increased stressors, when combined with parental learning disability, may lead to concerns about the care of children.

Disabled parents are sometimes targeted by individuals who may pose a risk to children and the children could in these situations be vulnerable to abuse and neglect.

Professionals should be alert to the possibility of significant harm and signs of neglect in children cared for by parents with disabilities. Children who may be more vulnerable are:

- Unborn babies or infants under one year old;
- Toddlers;
- Children with a disability or special educational needs;
- Children in a caring role;
- Children experiencing domestic abuse;
- Parents with a history of violence or sexual abuse.

Due to the increased vulnerability of this group of children they may require a rapid multi agency response to assess parent's disability and potential for adequate parenting.

The impact of the level of the disability of parents needs to be formally addressed at appropriate stages in the management of a case that involve neglect.

Ultimately, regardless of whether or not the parent has a learning disability, the quality of care experienced by the child determines whether or not a referral should be made for assessment by Children's Services.

Teenagers may be more able than their parents, if the parent(s) have 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.

Many parents with learning disabilities do not meet eligibility criteria for Adult Services. However it is important to remember that any safeguarding issues escalate eligibility status (see specific section for support services)

If you have any concerns about the children or adults you should contact Care Direct for Adults and for Children First Response.

Pre and post- natal check up

With Parents that have a learning disability, 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.

Parents with a learning disability will require additional support before the baby is born to understand what is happening, with easy read information, understandable antenatal classes and support at check-ups

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 ante-natal care is often jeopardized 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.

Parents with a learning disability may struggle to adjust to developmental changes in the child, i.e. eating solid food, walking and may need additional support at these times.

Assessment

With Parent with learning difficulties the assessment process should cover the following:

- Does the child take on roles and responsibilities within the home that are inappropriate?
- Does the parent/carer neglect their own and their child's physical and emotional needs?
- Does the learning disability result in chaotic structures within the home with regard to meal and bedtimes, etc.?
- Is there a lack of the recognition of safety for the child?
- Does the parent/carer misuse alcohol or other substances?
- Does the parent/carer's learning disability have implications for the child within school, attending health appointments etc?

- Does the parent/carer's learning disability result in them rejecting or being emotionally unavailable to the child?
- Does the child witness acts of violence or is the child subject to violence?
- Does the wider family understand the learning disability of the parent/carer, and the impact of this on the parent/carer's ability to meet the child's needs?
- Is the wider family able and willing to support the parent/carer so that the child's needs are met?
- Does culture, ethnicity, religion or any other factor relating to the family have implications on their understanding of the learning disability and the potential impact on the child?
- How the family functions, including conflict, potential family break up etc.
- Is the parent/carer vulnerable to being exploited by other people e.g. financially, providing accommodation?
- Does the parent/carer have difficulty developing and sustaining relationships or have relationships that may present a risk to the child?
- Does the parent have a limited understanding of the child's needs and development including pregnancy, childbirth, and caring for an infant?
- Does the parent/carer have poor parenting experiences from their own parents as a child?
- Does the parent/carer have difficulty accessing health care and other support for themselves or the child?
- In relation to pregnant women, should a pre-birth assessment be arranged?

The guidance indicates '**Five Key Features of Good Practice in working with parents with learning disabilities**':

1. Accessible information and communication
2. Clear and co-ordinated referral and assessment procedures and processes, eligibility criteria and care pathways
3. Support designed to meet the needs of parents and children based on assessments of their needs and strengths;
4. Long-term support where necessary;
5. Access to independent advocacy.

http://www.sclد.org.uk/wp-content/uploads/2015/06/Supported_Parenting_web.pdf

Professionals undertaking assessments must recognise that a learning disability is a lifelong condition. Assessments must therefore consider the implications for the child as they develop throughout childhood and will need to re-evaluate the child's circumstances from time to time. Children may exceed their parent's intellectual and social functioning at a relatively young age.

Where a parent with learning disabilities appears not to be able to meet her/his child's needs, a referral should be made to Children's social care in line with the Referrals procedure and they have a responsibility to assess need and where necessary, offer supportive or protective services.

Parents who offend

The Probation Service or community Rehabilitation Company are, well placed to identify offenders who pose a risk of harm to children as well as children who may be

at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour and of other poor outcomes due the offending behaviour of their parent/carer(s).

Where an adult offender is assessed as presenting a risk of serious harm to children, the offender manager should develop a risk management plan and supervision plan that contains a specific objective to manage and reduce the risk of harm to children.

In preparing a sentence plan, offender managers should consider how planned interventions might bear on parental responsibilities and whether the planned interventions could contribute to improved outcomes for children known to be in an existing relationship with the offender.

With teenage parents that offend this assessment will be undertaken by the Youth Offending Team.

Prison

The Prison Service has a responsibility to identify prisoners who pose a risk of harm to children. Where an individual has been identified as presenting a risk of harm to children, the relevant prison establishment:

- Should inform the local authority children's social care services of the offender's reception to prison and subsequent transfers and of the release address of the offender;
- Should notify the relevant probation service provider. The police should also be notified of the release address;
- May prevent or restrict a prisoner's contact with children. Decisions on the level of contact, if any, should be based on a multi-agency risk assessment. The assessment should draw on relevant risk information held by police, probation service provider and prison service. The relevant local authority Children's social care contribute to the multi-agency risk assessment by providing a report on the child's best interests. The best interests of the child will be paramount in the decision-making process;
- A prison is also able to monitor an individual's communication (including letters and telephone calls) to protect children where proportionate and necessary to the risk presented.

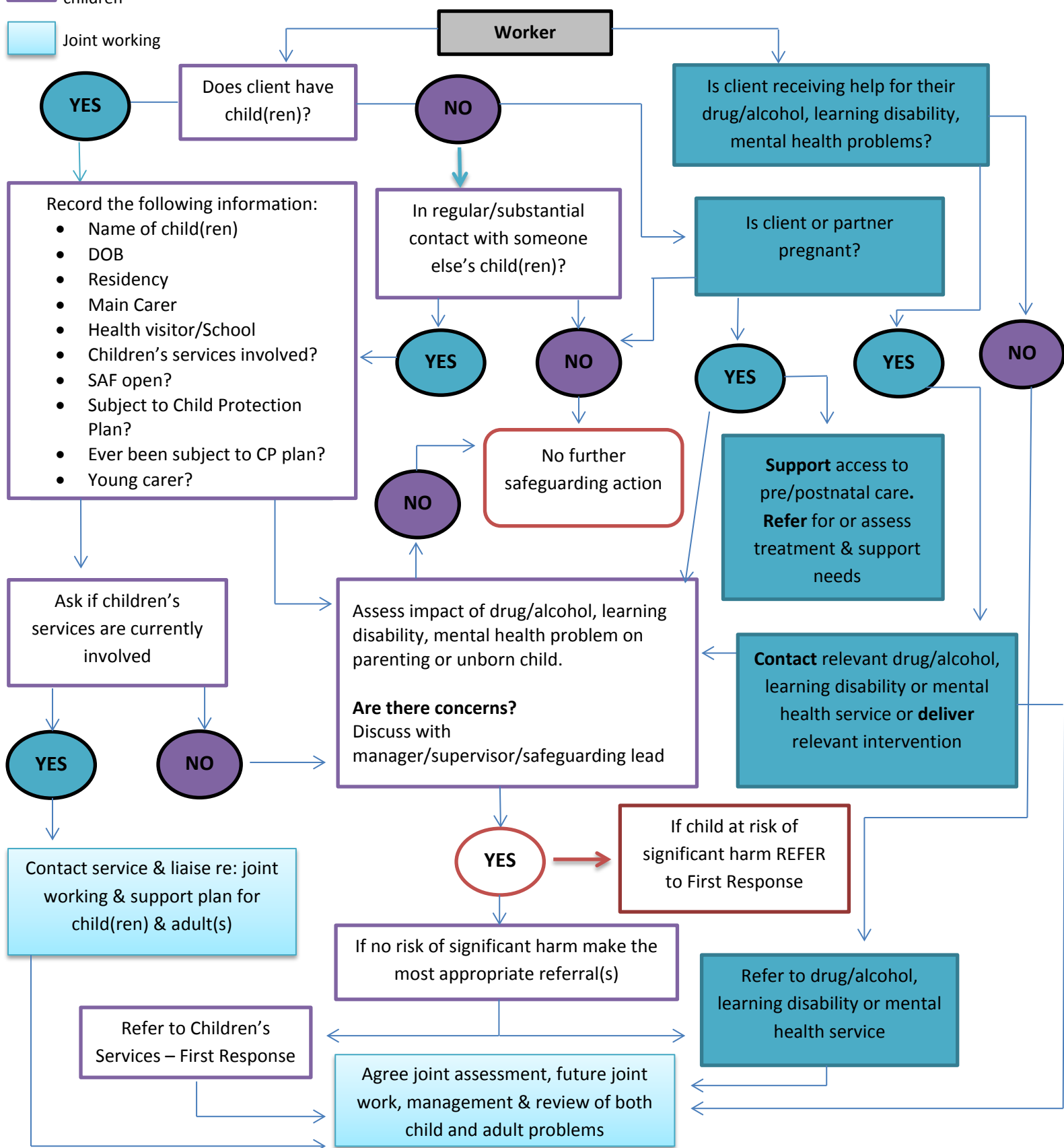
Governors/Directors of women's establishments which have Mother and Baby Units should ensure that:

- There is at all times a member of staff on duty in the unit who is proficient in child protection, health and safety and first aid/child resuscitation; and
- Each baby has a child care plan setting out how the best interests of the child will be maintained and promoted during the child's residence in the unit.

[SWCPP](#) provides detailed guidance for safeguarding children who visit parents in prison or secure establishment

Joint working protocol: safeguarding children flowchart

- Action re: adults
- Action re: children
- Joint working



Appendix – 2 Adult Referral Pathways

Issue	Adult Experiencing Mental Ill Health	Adult Experiencing Domestic Abuse	Adult requiring Care and Support Assessment	Adults Safeguarding Team - Care and Support	Prevent and Radicalisation
<p>Presentation</p>	<p>Depression, Anxiety/Panic attacks and phobias, Psychosis, OCD, Eating Disorder, Post traumatic Stress Disorder, Perinatal Mental Health, Drug and Alcohol Disorder, Autistic Spectrum Disorder, Dementia.</p>	<p>Adult discloses Domestic Abuse/ or Domestic Abuse is suspected. This includes coercive control.</p> <p>If the adult is in immediate danger or needing urgent medical attention contact Emergency Services.</p>	<p>People whose needs;</p> <ul style="list-style-type: none"> • arise from or are related to a physical or mental impairment or illness; • are unable to achieve two or more specified outcomes (see below) • significantly affect their wellbeing <p>and require a package of support to enable them to fulfil day-to-day tasks.</p> <p>OUTCOMES</p> <ol style="list-style-type: none"> 1) managing and maintaining nutrition 2) maintaining personal hygiene 3) managing toilet needs 4) being appropriately clothed 5) maintaining a habitable home environment 6) being able to make use of the home safely 7) developing and maintaining family or other personal relationships 8) accessing and engaging in work, training, education or volunteering 9) making use of 	<p>Safeguarding duties apply to an adult (aged 18 or over²) who:</p> <ul style="list-style-type: none"> • Has needs for care and support (whether or not the local authority is meeting any of those needs); and • Is experiencing or at risk of, abuse or neglect; and • As a result of their care and support needs is unable to protect themselves from either the risk or experience of abuse or neglect 	<p>Adult believed to be at risk of radicalisation – being drawn into acts of terrorism/violent extremism or inspired to become a lone attacker. Risk factors include:</p> <ul style="list-style-type: none"> • Accessing violent extremist websites; • Possessing or accessing violent extremist literature; • Using extremist narratives and a global ideology to explain personal disadvantage; • Justifying the use of violence to solve societal issues; • Joining or seeking to join

			necessary facilities or services in the local community including public transport and recreational facilities or services 10) carrying out any caring responsibilities the adult has for a child		
Pathway	<p>Self-Referral if mild to moderate e.g. Psychological therapies</p> <p>GP Referral for specialist Mental Health Services</p> <p>Crisis Service 24 hours a day – open access</p>	<p>Carry out CAADA DASH Risk assessment.</p> <p>If MARAC referral criteria passed (high risk indicators) refer to MARAC</p> <p>Consider referral to IDVA</p> <p>If the adult has care and support needs refer to Safeguarding Adult Team as well as MARAC</p> <p>If there is a child in the household refer to First Response Tel 0117 903 6444</p> <p>Give local support information. For a list of support services and resources follow this link to the BAVA website</p>	<p>The assessment will support the determination of whether needs are eligible for care and support from the local authority, and understanding how the provision of care and support may assist the adult in achieving their desired outcomes.</p> <p>An assessment must be person-centred, involving the individual and any carer that the adult has, or any other person they might want involved.</p> <p>Assessment is carried out by a trained assessor. Once assessed, the person's needs must be met by the local authority if someone is assessed as eligible. If criteria are not met the assessor should give consideration to preventative resources.</p>	<p>Referral to Safeguarding Team via Webform.</p> <p>If urgent contact the police on 999 or 101.</p>	<p>Inform Prevent Lead in agency</p> <p>If urgent call 999 and contact Police or not urgent 101 and refer to Prevent team</p> <p>A referral to Channel may be made by the Prevent team where a reported individual is assessed to need more intensive assistance.</p> <p>For guidance refer to leaflet Building the Bridge</p>
Relevant Policies	<p>Joint Perinatal Mental Health</p> <p>Joint Safeguarding Adults Policy</p> <p>Mental Capacity Act 2005</p>	<p>Joint Safeguarding Adults Policy</p> <p>MARAC Referral Process</p>	<p>Care and Support Statutory Guidance (Reviewed 2018)</p>	<p>Joint Safeguarding Adults Policy</p> <p>Organisational Abuse and conducting large scale investigations</p> <p>People in positions of trust</p> <p>Multi Agency Guidance</p> <p>Self Neglect</p> <p>KAS escalation</p>	<p>Useful Resources and information relating to Prevent</p> <p>PREVENT leaflet - Professionals</p> <p>PREVENT leaflet - Public</p> <p>Keeping Muslims safe online</p>

				procedure	Further Information on community safety Multi Faith Guide
Referral	<p>If an adult is in immediate mental health crisis and at risk to self or others call 999</p> <p>Crisis service - offers a telephone line to support people in mental health crisis and professionals and others who are supporting people in mental health crisis. This line is open 24 hours a day, every day. Urgent calls to 0300 5550334</p> <p>Non-urgent referral to Mental Health Services - Bristol Mental Health</p>	<p>Care Direct First Response (if a child/ren involved)</p> <p>Police Support Services including voluntary services</p> <p>IDVA</p> <p>MARAC</p>	<p>Trained local authority assessor. Assessment process start as soon as the local authority starts to collect information</p> <p>REFER VIA CARE DIRECT WEBFORM</p>	<p>SAFEGUARDING ADULTS REFERRAL WEBFORM</p> <p>Out of hours the Emergency Duty Team is available on Tel 01454 615 165 for both adult and children safeguarding issues. If child is at risk that is linked to the adult safeguarding needs refer to First Response Tel 0117 903 6444</p> <p>If doesn't meet threshold consider speaking to agencies commissioning or giving care, refer to other support services including voluntary, provide self-help information.</p>	<p>The Police's Prevent Team can be contacted: Telephone 01278 647466, or dial 101 (and ask for the 'Prevent Team' and explain you are calling about extremism or radicalisation)</p> <p>Email channelsw@avonandsomerset.pnn.police.uk</p> <p>Always dial 999 in an emergency</p>