

# **Safeguarding Children who have a Parent or Carer with Mental Health Problems**

## **Guidance for Effective Joint Working**

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5.0	November 2013	Carol Davies	Planned revision of document. Updated to reflect the latest edition of Working Together 2013. Further clarity and guidance added regarding the responsibilities of all staff to seek early help for children, as well as acting on safeguarding concerns.

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## 1. Purpose

This guidance is informed by national and local guidance and research as well as the findings of two local Serious Case Reviews<sup>1</sup>. These reviews have highlighted the importance of recognising that the onset of parental mental illness can present a risk to children *even when there is no previous history of mental health problems or illness, or abuse or neglect*.

The purpose of this guide is to help ensure that all staff working with children or families understands:

- the impact of parental mental health on parenting
- the impact that parental mental health may have on children
- the risks to children from parental mental illness
- how to work effectively with other agencies to help families and safeguard children
- The actions to be taken when concerns arise about the impact of parental mental illness on a child (including unborn children).

## 2. Definitions

The use of mental health 'language' in everyday situations can lead to misunderstandings; for example describing someone's behaviour as 'psychotic' or manic' when the behaviours may simply be unusual or odd. It is therefore very important to be as clear as possible about the exact nature of parental mental health problems in order to inform assessment, decision-making and the management of risks associated with parental mental health concerns.

For the purposes of clarity;

- The phrase 'people with mental health problems' emphasises and acknowledges that the person is a person first, not a psychiatric diagnosis, and, although many people experience mental distress, and this may be a 'problem', they do not necessarily have a mental illness.
- The term 'people with a mental illness' is a narrower definition and is often used by psychological and psychiatric services. By placing the emphasis on the word 'illness', it acknowledges the need for medical treatment, which may include medication or other treatment options such as Talking Therapies.

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<sup>1</sup>Executive summaries of Family T and Child F serious case reviews are available from  
- Family T - Peterborough LSCB – <http://www.safeguardingpeterborough.org.uk/children-board/serious-case-reviews/>  
- Child F - Cambridgeshire LSCB – <https://www.cambslscb.co.uk/serious-case-reviews/scr-published-by-cambs-lscb/>  
See also 'Learning lessons from serious case reviews 2010: <http://www.ofsted.gov.uk/resources/learning-lessons-serious-case-reviews-2009-2010>.

The experience of mental health problems or mental illness may be occasional, recurring or enduring, and symptoms and associated behaviours may fluctuate. It is always recommended to establish factual information about a parent's mental health as early as possible. If there is any suggestion of a significant mental health problem it is advised that clarification be sought via medical colleagues to ensure that all those working with a family have a shared understanding.

In this document where reference is made to 'parental mental health', the issues and risks could be equally applicable to other carers, family members, and household residents who may not be a biological parent to a child but nevertheless have care of or significant contact with a child.

Appendix A provides additional information about mental health conditions.

### 3. Background

- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves<sup>2</sup>.
- Of the 175,000 young carers identified in the 2001 census, 29 per cent – or just over 50,000 – are estimated to care for a family member with mental health problems<sup>3</sup>.
- Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90 per cent of parents on their caseload have mental health problems, alcohol or substance misuse issues<sup>4, 5</sup>.
- Between one in four and one in five adults will experience a mental illness during their lifetime:
  - At the time of their illness, at least a quarter to a half of these will be parents.
  - Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health.
  - The mental health of children is a strong predictor of their mental health in adulthood.
- Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting can impinge on adult mental health (see Diagram 1).

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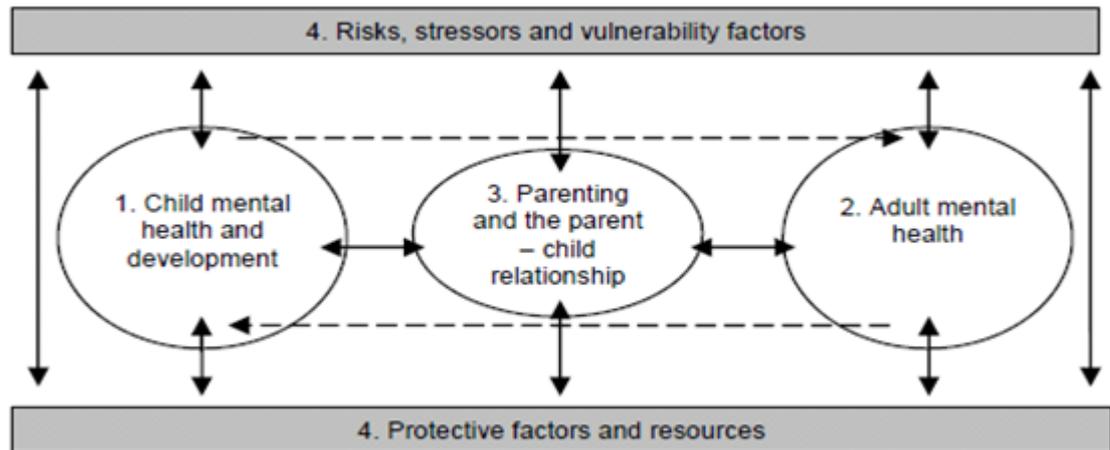
<sup>2</sup> Office of the Deputy Prime Minister (2004) Mental health and social exclusion, Social Exclusion Unit Report, London, ODPM

<sup>3</sup> Dearden, C. and Becker, S. (2004) Young carers in the UK: the 2004 report, London, Carers UK and The Children's Society.

<sup>4</sup> Layard, R. 2005. Mental Health: Britain's biggest social problem. (online) Available at: <http://cep.lse.ac.uk/textonly/research/mentalhealth/RL414d.pdf>

<sup>5</sup> Meltzer, H., Gatward, R., Goodman, R., & Ford, T. 2000. Mental health of children and adolescents in Great Britain. The Stationery Office: London

Diagram 1



The Family Model (Falkov 1998)

The two per cent of families who suffer the combined effect of parental illness, low income, educational attainment and poor housing are among the most vulnerable in society<sup>6</sup>

Despite these very significant issues, many parents or carers with mental health problems and mental illness are able to parent effectively. Their condition may be stable and any symptoms well-controlled. Effective family support and community networks can contribute to minimising any negative effects for parents, carers and children. Careful consideration must however be given to the impact an adult's mental health condition and symptoms may have on the child and what support the family may need as a whole.<sup>7</sup>

Some parents/carers with a severe mental illness *can* present a risk to their children. Where it is thought the child has experienced or is likely to experience significant harm as a result, the duty of care that a health professional owes to a child will take precedence over any obligation to the parent or other adult<sup>8</sup>. *The welfare of the child is paramount*<sup>9</sup>.

If concerns arise it is essential that all professionals involved with the family develop a shared understanding of the parental mental health problem and the specific risks this may pose to children. Close collaboration and liaison is required between professionals who, despite having differing roles and expertise, will need to work together to prioritise the needs of children.

This may include staff from adult mental health services, children's social care, schools, health visitors, school nurses and other local authority and voluntary sector workers.

<sup>6</sup> Cabinet Office, 2007. Reaching Out: Think Family. Social Inclusion Task Force – Cabinet Office.

<sup>7</sup> National Patient Safety Agency 2009 Preventing harm to children from parents with mental health needs (RRR003). <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59898>

<sup>8</sup> Patients as parents: Addressing the needs, including the safety of children whose parents have mental illness. Royal College of Psychiatrists 2011

. [www.rcpsych.ac.uk/files/pdfversion/cr164.pdf](http://www.rcpsych.ac.uk/files/pdfversion/cr164.pdf)

<sup>9</sup> Children Act 1989. <http://www.legislation.gov.uk/ukpga/1989/41/contents>

When the need for early help is identified such staff must be clear about how to access this, and, if there are child protection concerns, know how to make referrals to Children's Social Care. In all cases it is essential that information is shared at an early stage and effective communication takes place.

Achieving the best outcomes for children involves working collaboratively with families too. Professionals need to engage with parents at the earliest opportunity, as offering help early on may prevent problems or difficulties worsening. When multi-agency plans are developed (including child in need and child protection plans) these must be clear to everyone involved, as well as the family themselves.

#### **4. The impact of Parental Mental Health issues**

The mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked<sup>10</sup>. It is important to think beyond the parent's diagnosis. If a parent is unwell, this may have an impact on their ability to manage the challenges of daily family life.

An affected parent may not have insight into this, and so be unaware that their child may be in need of or would benefit from additional help, or indeed at risk of, or even experiencing harm.

The impact of parental health issues on the individual and their family will depend on many factors including:

- Individual differences; people with the same diagnosis can experience very different symptoms and behave in different ways. Impairment can change over time.
- The effects of medication and talking therapies; while the aim is to bring about positive health benefits for the affected individual, sometimes changes to medication or the consequences of therapy can trigger a worsening of symptoms in the short-term.
- The cumulative effect of other risk factors ( e.g. domestic abuse, drug and alcohol use, housing problems, financial problems, discrimination and stigma).
- The presence or lack of protective factors and resources (e.g. family network, isolation, community resources and other sources of support)
- The impact of life events (e.g. hospital admission, traumatic experiences, child protection conferences, moving house, physical health problems)

Whether or not a parent has a formal diagnosis e.g.; depression, bi-polar disorder, schizophrenia, it is important to understand how they experience their mental health problem. This will help you understand how it affects their role as a parent and the impact it may have on their children and family life.

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<sup>10</sup> Think child, think parent, think family: a guide to parental mental health and child welfare. Produced by Social Care Institute for Excellence (SCIE), updated December 2011: <http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf>

'Mental illness by its very nature, is a familial experience. A single member may exhibit symptoms, receive a diagnosis, and undergo treatment, but because of the interdependence that exists within a family system, each and every family member is affected in some specific way. Among the most vulnerable and most affected by a family member with a mental illness are the children who live with that member (Kinsela

## 5. Parental Mental Health from a child's perspective

When there are concerns about adults in the family, too often the focus on the child is lost. Adequate steps may not be taken to establish the wishes and feelings of children and young people, and their voice is not sufficiently heard (Ofsted 2013<sup>11</sup>).

It is especially important to reach an understanding from a child's perspective of how the parent/carer's mental health problem or illness affects them: whether the child feels safe as well as ascertaining first hand what their thoughts are about themselves, their parents and their family situation.

Involving children and young people will not only help to ensure that they are safeguarded but will result in better, more informed assessments and plans for them and their family. These are some of the things that children say about living in a family with parental mental health problems;

- Children often worry hospital will make their parents worse
- Children can worry that they might "catch" their parent's mental health problem
- They may want to visit the parents in hospital, or find it too scary to go<sup>12</sup>
- They may feel responsible for making their parents feel better
- They may have their own way of telling when their parent is becoming ill
- Many children feel isolated and that they cannot join in with others of their own age
- Academic success does not mean a child or young person is coping
- Some young people may feel they have gained some benefit from their experience of their parents mental illness
- Often no one explains anything to children or young person
- Children may not want formal counselling but may need someone to talk to<sup>13</sup>.

See Appendix B – Experiences of children and families

<sup>11</sup> <http://www.ofsted.gov.uk/resources/voice-of-child-learning-lessons-serious-case-reviews>

<sup>12</sup> [http://www.barnardos.org.uk/parents\\_in\\_hospital\\_july\\_2007.pdf](http://www.barnardos.org.uk/parents_in_hospital_july_2007.pdf)

<sup>13</sup> Falkov, A. (ed.) (1998) Crossing bridges: Training resources for working with mentally ill parents and their children – Reader for managers, practitioners and trainers. Brighton: Pavilion Publishing.

## 6. Information gathering and sharing

Promoting children's well-being and safeguarding them from harm crucially depends upon effective information sharing, collaboration and understanding between agencies and professionals.

Shortcomings around information sharing have previously been identified during agencies' attempts to help a family where there were support needs and/or safeguarding concerns. This seems to be because often the right information is either not sought or not shared. Clearly this is no less important when there are concerns around parental/carer mental health. It is therefore important to gather:

- the child's views
- information from or about fathers, whether living in the home or elsewhere, and other adults living in the home
- contributions from the extended family
- historical knowledge about members of the family
- relevant information from other agencies involved with the family
- the cultural background of the family
- factual information about actual or suspected medical diagnoses regarding the mental health of parents/carers
- research findings about abuse, neglect, domestic violence and substance misuse, where they may be relevant to the particular case

Reaching a shared understanding of the parental mental health problem is fundamental to a sound assessment and decision-making. Ask yourself 'Does everyone involved with the family understand the nature of the parental health problem and how it may impact on their parenting and the child?'

It is important to keep a balance between the need to maintain confidentiality and the need to share information to protect others. Wherever possible you should share your concerns with the child's parents, unless there is a good reason for not doing so, for example, if sharing it will place the child at increased risk of harm. The welfare of the child is paramount however and so there may be situations when it is necessary to share information without the consent of the parents in order to protect the child.

When you have concerns about a child, information sharing can start at an early stage, especially when you have the consent of the parents. There is usually at least one other agency who know the family (i.e. school, GP) and there may be others such as health visitors, school nurses, parent support advisors, social care and voluntary agencies you can contact for information and to share concerns.

Often, it is only when information from a number of sources has been shared and pulled together that it becomes clear that there are concerns a child is in need of protection or services.

Decisions to share information must always be based on professional judgement about the safety and well being of the individual and in accordance with legal, ethical and professional obligations. See also 'Information sharing: Guidance for Practitioners and Managers'. Available at: [www.ecm.gov.uk/informationsharing](http://www.ecm.gov.uk/informationsharing)

## **7. Communicating effectively about parental mental health problems**

It is important that all agencies working with the child and family understand the nature of the mental health problem or illness experienced by the parents or guardian. This will help to ensure that the child's needs are understood and inform any steps necessary safeguard and promote their welfare.

Wherever possible avoid using complex language that may not be understood by others or, if you do, provide an explanation of the term. Do not assume that others share the same level of understanding of the mental health disorder/illness and risks to the child as you.

The following questions will help mental health professionals and non-mental health professionals consider what information might be useful to share or seek when communicating about parental mental health problems. You might want to re-phrase to speak less formally when communicating with those affected;

- What are the common characteristics of illness/psychiatric condition? For example, what are the symptoms and how do they present? Are the symptoms continuous or recurring?
- How do the symptoms affect parenting capacity?
- What is the prognosis and are they responding to intervention?
- What is the history of engagement of the parent and their compliance with treatment?
- What (if any) is the medication prescribed to the parent and what are the side-effects (if any) of this, including failure of compliance?
- What is the parent's understanding of their clinical condition and to what degree are they responding to the service being provided?
- What interventions have the patient user found most useful?
- What is likely in your opinion to help or hinder the parent?
- What is the nature of the relationship between the parent and their children?
- Is the parent aware of the impact that their condition may have on their children?
- In what way does the parent's care plan take account of the needs of their children?
- Are you aware of any views that the children may have?
- Does the parent pose any risks to the children? If so, be specific.
- Is there a possibility of relapse, and if so what might that look or feel like – their 'relapse signature'.

## 8. General Assessment Principles

Effective assessment supports the identification of need so that Early Help, Child in Need or Child Protection concerns can be addressed appropriately. The Framework for the Assessment of Children in Need and Their Families<sup>14</sup> is a useful generic tool to enable a systematic approach to comprehensive assessment. The outcomes can be used to consider a child's needs in the context of parenting capacity, developmental needs and family and environmental factors, including the interplay between domains (See Appendix F).

The interaction of these domains requires careful investigation during the assessment. The aim is to reach a judgement about the nature and level of needs and/or risks that the child may be facing within their family. It is important that;

- information is gathered and recorded systematically;
- information is checked and discussed with the child and their parents/carers where appropriate;
- differences in views about information are recorded; and
- the impact of what is happening to the child is clearly identified.

Factors to be considered include the impact of high-risk factors such as poverty, living in an area with high levels of crime, poor housing, high unemployment, domestic abuse, substance misuse, learning disability, racism and other forms of isolation. Other issues such as the vulnerability of children of new arrivals in the country and the potential significance of 'absent fathers' and other significant males in the family all need to be considered.

Please refer to more detailed guidance about assessment in Local Safeguarding Children Board Core Interagency procedures;

- <http://www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/>
- <http://cambridgeshirescb.proceduresonline.com/index.htm>
- Working Together to Safeguarding Children 2015<sup>15</sup>

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<sup>14</sup> Contained within Working Together to Safeguard Children 2015: <http://www.workingtogetheronline.co.uk/chapters/contents.html>

<sup>15</sup> Ibid.

## **9. Assessment in the context of Parental Mental Health issues**

### **Meeting Children's Developmental Needs**

In assessing whether the developmental needs of children are being met, the following areas should be considered;

- Does the parent/carer generally anticipate the child's need for food, clothing, sleep, play and safety?
- Does the parent/carer respond to the child's initiatives, offer warm interactions and respond appropriately to distress?
- Does the parent/carer refer to the child positively, or describe them with warmth?
- Does the parent/carer set age - appropriate boundaries to the child's behaviour?
- Does the parent/carer expect to "look after" the child, rather than the child being expected to "look after" the parent?
- Does the parent/carer offer a consistent and continuing relationship with the child over time?
- Does the parent/carer manage any periods of separation taking into account the needs of the individual child?
- As the child develops, is he or she supported in relationships with the world outside of the immediate household?
- Is the child free from abuse?
- Does the child attend school or nursery regularly (if applicable)?
- Is the child's health and development that which is expected for their age?

### **Parenting Capacity**

- Does the parent/carer display inappropriate behaviour in front of the child?
- Does the parent/carer appear to be hearing/ responding to voices?
- Does the parent/carer view the world as a friendly or hostile place?
- Is the parent/carer experiencing any sleep or appetite disturbance?
- Is the parent/carer's self-care adequate?
- Is the parent/carer able to leave the house?
- Does the parent/carer leave the house impulsively?
- Is the parent/carer taking prescribed medication in relation to mental health needs?
- Does the parent/carer leave the children without making adequate arrangements for their care?
- Does the parent/carer display episodes of severe withdrawal or irritability?
- Does the parent/carer display unusual and/or bizarre beliefs about the child?

## **Family and environmental factors**

- Is there another parent/carer who can provide compensatory care when needed?
- Are close relatives including spouse/partner aware of any mental health issues?
- Do they have the capacity to be supportive to the parents and/or the children and is their support accepted?
- Is the parent/carer accepting of help and treatment offered from professional/voluntary agencies involved?
- Is there parental/partnership conflict/family violence?
- Is accommodation adequate for children - e.g. clean, warm, safe, with enough food?
- Are parents/carers ensuring that household bills are paid?
- Does the family have a settled home base?
- Is the parent/carer using alcohol and/or drugs as well as prescribed medication?
- What is the parents' perception of the situation?
- Does the parent/carer acknowledge any mental health problems?
- Is the parent/carer able to think about and meet their child's needs?

### **A comprehensive assessment should therefore;**

- consider the needs of the child, parent/carer, and family as a whole
- include strengths and resources as well as risks and problem areas
- describe present and future needs e.g. the needs when a parent is well and when they are unwell
- involve all family members
- be based on information shared between all agencies involved with the family.

Those who have a role in working with these parents/carers must ensure that both the expertise of adult mental health workers and child care workers is used to inform any assessment regarding the welfare of the children.

## **10. Young Carers**

You may discover during the process of assessment that a child is in fact acting as a carer to their parent. Young Carers are children and young people who assume important caring responsibilities e.g. for parents or siblings who are disabled, have physical or mental ill health problems, or misuse drugs or alcohol. They are not necessarily 'children in need', but their needs should be carefully assessed. All carers, including young carers, should be advised of available information and resources. You should consider completing an Early Help Assessment (EHA) as a first step – see Key Contactsp.26).

## 11. Additional Risk Assessment around Parental Mental Illness

It should not be assumed that all parents with a mental health problem pose a risk to their children. Often a comprehensive assessment, collaborative working and careful planning will help minimise any potential impact on the child. There are however situations where children are at risk due to the nature of the parent's mental illness and its impact on their parenting.

According to the National Patient Safety Agency (NPSA 2009<sup>16</sup>) some clinical presentations pose a particularly high risk to children if present in a parent or carer. A referral must be made to Children's Social Care if:

- A service user expresses delusional beliefs involving their child and/or
- A service user makes threats to harm their child or might do so as part of a suicide plan.

Delusional beliefs are an example of 'psychotic' symptom which may occur in some serious mental illnesses. See Appendix A for a description of what is meant by 'delusional beliefs' and 'psychosis'.

Many service users of mental health services are assessed using the Care Programme Approach (CPA<sup>17</sup>). This includes an analysis of the person's health and social care needs including the presenting problem and a risk assessment. It should also identify any safeguarding children concerns and how these will be managed. A care plan will be produced, and each service user will be offered their own copy.

Every parent with a CPA care plan will also have an allocated 'care coordinator' or if in hospital a 'named nurse', responsible for keeping in close contact with the service user to monitor and co-ordinate care. Thought should always be given to sharing a CPA care plan with key professionals involved with the family. It could also be shared with relevant family members who may also play a part in providing care. This should lead to better plans for the child and family, as well as ensuring others are aware of any potential risks to the child.

Information sharing can take place at CPA reviews which can involve a number of agencies. CPA reviews can also be undertaken at the same time as child protection 'core group' meetings.

If you are providing care or support to the family and are not aware of the parent's CPA care plan, you can ask the 'care-co-ordinator' to explain the contents. They will of course be guided by information sharing protocols, but much of it can be shared easily with the consent of the parent.

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<sup>16</sup> National Patient Safety Agency 2009 Preventing harm to children from parents with mental health needs (RRR003).  
<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59898>

<sup>17</sup> <http://www.scie.org.uk/publications/guides/guide30/files/CPAbriefing.pdf>

See Appendix D for information about managing hospital admissions.

### **Managing risk**

#### **Learning points from local serious case reviews (Family A and Child F)**

- Where parental psychosis is identified, mental health services should clearly outline the specific behaviours that might be evident during a period of illness.
- It is important to understand a patient's 'relapse signature'. For example, if a patient has presented a risk to a child during a previous psychotic episode then this must be considered a potential risk during a future relapse e.g. actual physical harm or threats to harm.

### **Managing risk**

#### **Learning points from local serious case reviews (Family A and Child F)**

- It is important that all agencies involved understand how to recognise the early warning signs of a relapse, the triggers for deterioration and the specific risks to children that may result.
- Mental health staff have an important part to play in communicating risks to other agencies. Non mental health staff should take steps to seek a better understanding if they are unclear.
- Child protection plans in cases of parental mental health should be categorised into two sections: plans for when the parent is well, and plans for periods of ill health.
- If detailed monitoring /visiting plans are agreed between agencies, they should be written down and circulated, with a clear managerial lead from one agency, about who is responsible for ensuring the plans are followed.

## **12. Analysing the outcomes of assessment and acting on concerns**

Analysing the outcomes of assessment and any concerns should be informed by local thresholds for intervention:

- Cambridgeshire LSCB Threshold Document:  
<https://www.cambslscb.co.uk/report-a-safeguarding-concern/>
- Peterborough LSCB Threshold Document:  
<http://www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/threshold-document/>

- **Seeking Early Help**

You may find circumstances where although you do not think the child is at risk of significant harm you feel that their health or development could be otherwise disadvantaged without additional help. It is not always necessary in many circumstances to involve Children's Social Care. Good sources of information about help available can be provided by these agencies;

Peterborough

<http://fis.peterborough.gov.uk/kb5/peterborough/fsd/home.page>

Cambridgeshire

<https://www.cambridgeshire.gov.uk/residents/working-together-children-families-and-adults/how-we-work/children-and-families-services/>

The completion of an Early Help Assessment (EHA) may also help to further clarify any issues and concerns affecting a child. This standard assessment form also covers three domains: development of the child or young person, parents and carers, and family and environment (See also Key Contacts p.26). You could also consider completing a Keeping Children Safe Assessment tool as an alternative (see Appendix F).

Inter-agency work should start as soon as there are concerns about a child's welfare - not just when there is a child protection concern. If however you later find that you have concerns about a child's well-being you can also use the EHA or a completed Keeping Children Safe Assessment tool to support any referral to Children's Social Care.

Occasionally you may find that parents do not consent to an EHA being completed, or the EHA process does not achieve what was intended. If your worries about the child's wellbeing remain you should consider making a referral to Children's Social Care. If at any point you come to believe that the child is at risk of or actually experiencing significant harm then you must refer without delay.

See also Appendix C – getting help for parents with mental health problems.

- **Referrals to Children's Social Care**<sup>18</sup>

### **Children in Need**

If multi-agency work with the child and family early on does not result in a plan which is meeting the needs of the child a referral should be made to Children's Social Care who have a duty to undertake an initial assessment.

You can make referrals to Children's Social Care using the Joint Referral Form<sup>19</sup>.

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<sup>18</sup> <http://www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/making-referrals-to-childrens-social-care/>

Once an initial assessment has been undertaken this may result in the child being made subject to a 'child in need' plan under Sec 17 of the Children's Act 1989.

Child in need plans are implemented and monitored in a similar way to child protection plans. An initial meeting is held followed by review meetings at regular intervals thereafter to monitor the implementation of the plan. In some circumstances the child may move between the 'child in need' and 'child protection' process as the level of risk and the needs of the child change.

### **Children at Risk of Significant Harm**

If you think that a child has experienced or is likely to experience significant harm, whether as a consequence of concerns around parental mental illness or other risk factors you must make a referral to Children's Social Care without delay. Do not assume that someone else has made a referral or expect someone else to act on your concerns.

A referral *must* be made to Children's Social Care if:

- a service user expresses delusional beliefs involving their child and/or
- a service user makes threats to harm their child or might do so as part of a suicide plan.

A referral to Children's Social Care *should be considered* if the following are present:

- A history of severe mental illness
- self-harming behaviour and suicide attempts
- altered states of consciousness – e.g. splitting/dissociation, misuse of drugs, alcohol, medication
- obsessional compulsive behaviours involving the child
- non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on the child
- disorders designated 'untreatable', either totally or within timescales compatible with the child's best interests
- domestic violence and/or relationship difficulties
- unsupported and/or isolated parents

You can make referrals to Children's Social Care using the Joint Referral Form. Once an initial assessment has been undertaken this may result in the child being made subject to a 'Child Protection' plan under Sec 47 of the Children's Act 1989.

An initial Child protection conference may be convened, a Child Protection plan devised and thereafter core groups held to monitor progress made to reduce risks to children. In some circumstances the child may move between the 'child protection' and 'child in need' processes and as the level of risk and the needs of the child change.

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<sup>19</sup> <http://www.safeguardingpeterborough.org.uk/children-board/reporting-concerns/>

Any professional who has had contact with the child or family, however minimal, is expected to contribute to the child protection process including attending child protection conferences and submitting reports. This is especially important for staff working with parents with mental illness, as their expertise is likely to be relied upon in supporting other non-specialists in Mental Health. This can be critical to helping others to reach an understanding of the impact of the parent's health upon the health and well-being of the child.

### **13. Working with Children and Parents who are Difficult to Engage**

Sometimes parents who experience mental health symptoms may appear to be less co-operative than they might ordinarily be when otherwise well. Parents can of course present as hostile or non-compliant for any number of other reasons, which can impede the assessment and support process for children. Further guidance is available regarding working with hostile, non compliant clients and those who use disguised compliance within the context of safeguarding children<sup>20,21</sup>.

### **14. Professional Disagreements and Escalation**

At no time must professional disagreement detract from ensuring the child is safeguarded. The child's welfare and safety must remain paramount throughout.

It is important that there is respectful and constructive challenge whenever a professional or agency has a concern about the action or inaction of another. Similarly, professionals should not be defensive if challenged, and always prepared to review decisions and plans with an open mind. Professional disagreement is only dysfunctional if not resolved in a constructive and timely fashion. Common disagreements can arise as a result of differing view of service thresholds, lack of understanding of roles and responsibilities, or the need for action and communication.

The aim should be to resolve difficulties at practitioner/fieldworker level between agencies if necessary with the involvement of their supervisors or managers, engaging in open discussion with colleagues in other agencies. Both Cambridgeshire and Peterborough LSCB's have an Escalation Policy which offer guidance on how to manage such challenging situations<sup>22,23</sup>.

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<sup>20</sup> [http://peterboroughscb.proceduresonline.com/chapters/xg\\_violent\\_clients.htm](http://peterboroughscb.proceduresonline.com/chapters/xg_violent_clients.htm)

<sup>21</sup> [http://www.cambslscb.org.uk/user\\_controlled\\_lcms\\_area/uploaded\\_files/Workin\\_Ch\\_Par\\_difficult\\_engage\\_handbook.pdf](http://www.cambslscb.org.uk/user_controlled_lcms_area/uploaded_files/Workin_Ch_Par_difficult_engage_handbook.pdf)

<sup>22</sup> [http://cambridgeshirescb.proceduresonline.com/chapters/p\\_escalation.html](http://cambridgeshirescb.proceduresonline.com/chapters/p_escalation.html)

<sup>23</sup> [http://peterboroughscb.proceduresonline.com/chapters/xp\\_escalation.html](http://peterboroughscb.proceduresonline.com/chapters/xp_escalation.html)

## **Appendix A - Mental Health Conditions**

### **Antenatal Depression**

The most common mental health problem that develops during pregnancy is mixed anxiety and depression. It should not be assumed that the symptoms are the natural consequences of pregnancy. Simple measures may be sufficient to improve well being, including support and advice from a health visitor, midwife or GP. If this is not sufficient medication and talking therapies can be effective but need to be available in a timely fashion.

For women suffering with antenatal depression establishing links between mental health services, the midwife, the GP and the health visitor should be routine. Advice is also available from Peri-natal nurse specialists employed by Cambridgeshire and Peterborough NHS Foundation Trust and Named Midwives for Safeguarding and Vulnerable Women. See Key Contacts p.26.

### **Bi Polar Disorder**

Bipolar disorder, also known as manic depression, is a mood disorder characterised by swings in a person's mood from high to low - euphoric to depressed.

In the high phase (also referred to as hypomania), someone with bipolar disorder may have huge amounts of energy and feel little need for sleep. They may think and talk faster than usual, and their thoughts may jump rapidly from one subject to another, making conversation difficult. They may also have what are called 'grandiose' ideas or delusions about their abilities and powers, and a loss of judgement. People in a high phase can get themselves into all sorts of difficulties that they would normally avoid – they may leave their job, spend money they don't have, or give away all their possessions.

In a low (or depressive) phase, people feel hopeless, despairing and lethargic, become full of self-blame and self-doubt and have difficulty concentrating. This can make it difficult to cope with everyday life. They may want to withdraw from friends and social contacts, and may feel suicidal.

### **Postnatal Depression**

Depression in the postnatal period is the most common mental health problem for women in the period following childbirth. Women who are socially isolated and single parents may be particularly vulnerable. Women experience general symptoms such as lowered mood, sleep disturbance and lack of pleasure, but alongside this may be increased worry about their baby and a loss of enjoyment and joy in motherhood. Affected women will benefit from support from health visitor, GP, local groups and accessing mental health treatment, including talking therapies.

## Psychosis

Psychosis is a condition that affects a person's mind and causes changes to the way that they think, feel and behave. A person who experiences psychosis may be unable to distinguish between reality and their imagination. People who are experiencing psychosis are sometimes referred to as 'psychotic'. They may have:

- **Unusual beliefs called delusions.** These very strong beliefs are obviously untrue to others, but not to the sufferer. For example, thinking there is a plot to harm them, or that they are being spied on by the TV, or have been taken over by aliens. Sometimes, they may feel they have special powers.
- **Thought disorder** is when a person cannot think straight. Ideas may seem jumbled, but it is more than being muddled or confused. Other people will find it very difficult to follow what the person says.
- **Hallucinations** are when the person can see, hear, smell or feel something that isn't really there. The most common hallucination that people have is hearing voices. Hallucinations are very real to the person having them. This can be very frightening and can make the person believe that they are being watched or picked on.

Psychosis is not a condition in itself, it is a symptom of other conditions. The most common cause of psychosis is a mental health condition, such as schizophrenia or bipolar disorder (manic depression). Psychosis can also be triggered by physical conditions, such as Parkinson's disease, or as a result of drug or alcohol misuse. The length of time that someone will experience a psychotic state of mind, known as a psychotic episode, will depend on the underlying causes. Drug or alcohol-induced psychosis many only last for a few days. However, psychosis that results from schizophrenia or bipolar disorder may last indefinitely unless it is treated.

## Puerperal psychosis

Puerperal psychosis (also known as postpartum psychosis) is a psychotic episode in the post-natal period, usually within a few days after childbirth. It should be considered a psychiatric emergency. This is a relatively rare but serious and acute illness (1-2 in every 1000 births). Many women will have no previous history of mental illness but some may have been diagnosed with a bi polar illness or have a family history of mental illness.

Women presenting with early signs may be profoundly distressed and disturbed, experience fear and perplexity, hallucinations and delusions, restlessness and agitation, and/or feelings of elation or deep depression. Due to the severity of the illness it is likely that the mother's parenting capacity will be affected during the time of illness, in some cases presenting a significant risk to the baby. The needs of the child and family, (including contact with the child) will need to be carefully and sensitively considered and any safeguarding concerns addressed.

A significant number of women with puerperal psychosis will go on to be diagnosed with a bi polar illness and the treatment is the same.

For women with puerperal psychosis admission to hospital is likely (often to a Mother and Baby unit) and drug treatment is important. Recovery rates are good and women often respond well to appropriate care.

## **Schizophrenia**

Schizophrenia is a serious mental illness characterised by disturbances in a person's thoughts, perceptions, emotions and behaviour. However many people diagnosed with schizophrenia, and some professionals, dispute whether there is such a condition.

Schizophrenia is an umbrella diagnosis used to describe a wide range of symptoms. During an episode of schizophrenia, a person may lose touch with reality, see or hear things that are not there, hold irrational or unfounded beliefs, and appear to act strangely because they are responding to these delusions and hallucinations. An episode of schizophrenia can last for several weeks and can be very frightening.

## **Personality Disorders**

Personality disorders are a group of conditions characterised by an inability to get on with other people and learn from experience. People with a personality disorder may find that their beliefs and attitudes are different from those of most other people. Others may find their behaviour unusual, unexpected or perhaps offensive.

Personality disorders usually become apparent in adolescence or early adulthood, although they can start in childhood. People with a personality disorder may find it difficult to start or maintain relationships, or to work effectively with others. As a result, many may feel hurt, distressed, alienated and alone.

Personality disorders affect how a person thinks and behaves, making it hard for them to live a normal life. People diagnosed with personality disorder may be very inflexible – they may have a narrow range of attitudes, behaviours and coping mechanisms which they can't change easily, if at all. They may not understand why they need to change, as they do not feel they have a problem.

Personality disorder is a controversial diagnosis. They are very deep-rooted, so hard to treat, but people can be helped to manage their difficulties. There are no accurate figures, but an estimated 10% of the general population have some kind of personality disorder. The risk of suicide in someone with a personality disorder is about three times higher than average. People who think they may be suffering from a personality disorder should consult a GP.

For information about other mental health conditions and illnesses see <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/> - 'A complete guide to Mental Health problems, topical issues and treatment options'.

## APPENDIX B - Getting Help for Parents with Mental Health Problems

### Accessing Help

A good source of information about the services can be found via the public website of Cambridgeshire and Peterborough NHS Foundation Trust:

- <http://www.cpft.nhs.uk/help/>
- <http://cap.nhs.sitekit.net/services>
- <http://cap.nhs.sitekit.net/carers/>

For adults not already known to CPFT mental health services and their carers, it is advised that a first point of contact should be their GP, who will be able to undertake an initial assessment of their needs and be able to review their care records. This is especially important as they may have physical health needs affecting their mental health. During normal working hours contact the relevant GP surgery. Out of hours the answerphone message should provide you with an alternative telephone number to call if necessary in a crisis. If there could be a danger of harm to the individual or others then call the Police.

The **ARC** (Advice and Referral Centre) is a new Contact Centre operating 24 hours a day, seven days a week providing an age inclusive Single Point of Access into CPFT services for GPs and other referrers;

Advice and Referral Centre Telephone	0845 045 0123
Fax	0845 045 0121
E-mail	cpft.arc@nhs.net



### Help in a crisis

For existing CPFT service users during normal working hours (Monday to Friday 09.00 to 17.00 the first point of contact should be your Care Co-ordinator.

An out-of-hours telephone service is available to CPFT's service users who are experiencing a crisis in their mental health and feel that they need to seek immediate advice. This service is also available for carers who are concerned about the mental health of the service user; Mondays to Fridays: 17:00 to 22:00 Saturdays, Sundays and Bank Holidays: 08:00 to 22:00

Everyone is, of course, entitled to attend the local A&E for an assessment of their health. In an emergency call 999.

A number of voluntary organisations also provide help to adults with mental health problems, including MIND, the Richmond Fellowship and Sane. Helplines include:

Lifeline - 0808 808 2121 - a free confidential support service across Cambridgeshire between 7.00pm and 11.00pm, 365 days a year.

Samaritans - 08457 90 90 90

Sane - 0845 767 8000

## Appendix C - Experiences of Children and Families

### Children

A group of young carers of parents with mental health problems in Merseyside came up with following 10 messages as a simple checklist for practitioners who come into contact with such families<sup>24</sup>;

1. Introduce yourself. Tell us who you are. What your job is.
2. Give us as much information as you can.
3. Tell us what is wrong with our mum or dad.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know, and what we think. We live with our mum or dad. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live there too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. **MAYBE IT COULD BE YOU.**

### Parents

Some parents will find being involved with services, and especially child protection conferences and the period around them very stressful. Consideration must be given therefore, with multi-disciplinary colleagues, to what additional support the family may need during this time. As well as help for their own mental health problem, parents have said they would like to see:

- More understanding and less stigma and discrimination in relation to mental health problems
- Support in looking after their children
- Practical support and services
- Good quality services to meet the needs of their children
- Parent support groups
- Child-centred provision for children to visit them in hospital
- On-going support from services beyond periods of crisis
- Continuity in key-worker support
- Freedom from fear that children will inevitably be removed from them (Falkov 1998)<sup>25</sup>

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<sup>24</sup> [http://www.barnardos.org.uk/parents\\_in\\_hospital\\_july\\_2007.pdf](http://www.barnardos.org.uk/parents_in_hospital_july_2007.pdf)

<sup>25</sup> Adrian Falkov (Ed) (1998) Crossing Bridges. Training resources for working with mentally ill parents and their children.

## APPENDIX D – Managing Hospital Admissions<sup>26</sup>

The following questions will help you consider how you can ensure the needs of children are considered alongside those of the parent during an admission to hospital;

- Are the children safe?
- How have you assured yourself that this is the case?
- Has key information about the children been documented during admission? This will enable you to consider their needs whilst the parent/guardian is in hospital and plan discharge effectively. *Including, names, date of birth, school, GP.*
- Who is in the family?
- Do you have detailed knowledge of who is looking after the children whilst the parent is in hospital?
- Have you communicated with others involved with providing care/support to the parent or others in the family? For example, health visitors, school nurses, GP, mental health services, voluntary sector, Children's Social Care. You can contact the Safeguarding Children Team of CPFT if you need help to locate other professionals working with the family – see Key Contacts.
- Does the parent's CPA care plan include a contingency/ crisis plan to manage future admissions and has it been shared with other professionals involved with the family?
- Have any financial and housing issues arising from hospitalisation (e.g. interruptions in welfare benefits, assistance with child care to avoid a parent or carer having to take unpaid leave to look after the children during this time) been considered?
- Are the children's school aware of the temporary changes in the family to help ease the path of return when the parent returns home?
- Has anyone explained the admission to the children?
- Have their views and wishes been taken into account?
- Have the children been offered the opportunity to visit their parent in hospital?
- If a service user is being discharged to another service (e.g. GP, community mental health team) has relevant up-to-date information been shared with the receiving team or service prior to or on the day of discharge? *Including any information relating to safeguarding children.*
- Has a discharge planning meeting been arranged, with the relevant agencies/professionals invited. Has the outcome of the meeting been communicated properly? *Including updated CPA Care Plan, risk assessment, contingency/ crisis plan detailing any issues related to safeguarding children.*

Sharing information well in advance of discharge will help agencies work together effectively and allow professionals to work collaboratively with the family to ensure discharge is managed safely. If concerns arise about the welfare of the children during a hospital stay, seeking help and communicating with relevant agencies should not wait until discharge.

Do not assume that information passed to one agency will automatically be passed to others involved with the family. You will need to communicate with each agency individually.

<sup>26</sup> Please also refer to LSCB Interagency Procedures;

- [http://cambridgeshirescb.proceduresonline.com/chapters/xp\\_ch\\_visit\\_hosps.html](http://cambridgeshirescb.proceduresonline.com/chapters/xp_ch_visit_hosps.html)
- [http://peterboroughscb.proceduresonline.com/chapters/xp\\_ch\\_visit\\_hosps.html](http://peterboroughscb.proceduresonline.com/chapters/xp_ch_visit_hosps.html)

## Appendix E – Key Contacts and Useful Resources

### Cambridgeshire and Peterborough NHS Foundation Trust

- **Safeguarding Children Team**

Team Administrator - 01733 777961

Safe haven Fax - 01733 777938

Secure E-mail – [cpm-tr.CPFTsafeguardingchildren@nhs.net](mailto:cpm-tr.CPFTsafeguardingchildren@nhs.net)

- **Perinatal Mental Health specialists**

Consultant Psychiatrist - Lead for Peri-Natal Mental Illness

Nightingale Court, Cambridge 01223 884488

Perinatal Nurse Specialist Peterborough wef November 2013

Peri-natal Nurse Specialist Newton Centre, Huntingdon 01480 415340

Peri-natal Nurse Specialist Agenoria House, Wisbech 01945 482100

Peri-natal Nurse Specialist Union House, Cambridge 01223 533300

### Midwifery Contacts

- Named Midwife for Safeguarding Children / Vulnerable Women  
The Rosie Maternity Hospital Cambridge 01223 348988
- Named Midwife for Safeguarding Children  
Hinchingsbrooke Hospital Huntingdon 01480 416445
- Named Midwife for Safeguarding and Lead Midwife for Vulnerable Women  
Peterborough 01733 673775
- Advanced Midwifery Practitioner Peterborough 01733 673776

### Local Safeguarding Children Boards

- Peterborough: <http://www.safeguardingpeterborough.org.uk/children-board>  
Interagency Procedures: [www.proceduresonline.com/peterboroughscb](http://www.proceduresonline.com/peterboroughscb)  
Telephone: 01733 863475
- Cambridgeshire: <http://www.cambslscb.co.uk/>  
Interagency Procedures: [www.proceduresonline.com/cambridgeshirescb](http://www.proceduresonline.com/cambridgeshirescb)  
Telephone: 01480 373522

### Children's Social Care

- **Cambridgeshire Children's Social Care**  
**Telephone** - 0345 045 1362. Out-of-hours Emergency Duty Team - 01733 234724.  
**Fax** - 01480 376748

**Post:** Cambridgeshire Direct, Children's Team, PO Box 14, St Ives, Cambs PE27 9AU

**E-mail** - [referralcentre.childrens@cambridgeshire.gcsx.gov.uk](mailto:referralcentre.childrens@cambridgeshire.gcsx.gov.uk)

Joint Referral Form - <http://www.safeguardingpeterborough.org.uk/children-board/reporting-concerns/> Click the link to Safeguarding Referral Form

- **Cambridgeshire CAF**

Before starting the EHA process, the practitioner should contact the EHA Team on 01480 376666 or e-mail [Early.help@cambridgeshire.gcsx.gov.uk](mailto:Early.help@cambridgeshire.gcsx.gov.uk) to check if a EHA already exists.

- **Peterborough Children's Social Care**

**Telephone** - 01733 864170/80. Out-of-hours Emergency Duty Team - 01733 234724.

**Fax** - 0870 2384083

**Post:** Children's Social Care, Initial Enquiries Referral and Assessment Team (Children & Families), Children's Services, 1st Floor Bayard Place, Broadway, Peterborough, Cambs, PE1 1AY.

**E-mail** - [cscrecords@peterborough.gcsx.gov.uk](mailto:cscrecords@peterborough.gcsx.gov.uk)

Joint Referral Form - <http://www.safeguardingpeterborough.org.uk/children-board/reporting-concerns/> Click the link to the referral form;

- **Peterborough CAF**

For more information on the EHA visit:

<https://www.peterborough.gov.uk/healthcare/early-help/>

## Useful Resources

- Parental mental Health and Child welfare Network  
<http://www.pmhcwn.org.uk/index.asp>
- Making Time to Talk. Advice for parents with mental illness NSF Scotland  
<http://www.pmhcwn.org.uk/resources.asp>
- Children of Parents with Mental Illness ([www.COPMI.net.au](http://www.COPMI.net.au))
- MIND <http://www.mind.org.uk/Information/Factsheets/>
- Wishing Wellness: A Workbook for Children of Parents with Mental Illness – Lisa Anne Clarke
- Why Are You So Sad: A Child's Book About Parental Depression – Beth Andrews
- Mommy Stayed in Bed This Morning: Helping Children Understand Depression - Mary Wenger Weaver.
- <http://www.carers.org/>
- <http://www.youngminds.org.uk/>

# Cambridgeshire and Peterborough

NHS Foundation Trust



## The Keeping Children Safe Assessment Tool

Prepared for use by Services working with Adults

November 2013

Adapted from South Tyneside Safeguarding Children Board Think Family Keeping Children Safe Assessment Tool 2011

### Part One – Introduction

This guidance consists of two parts; Part One is an introduction and information about the 'Assessment Triangle' to support the use of the Keeping Children Safe Assessment tool, while Part Two is the actual tool itself, some suggested questions to help you complete it, a scoring guide, and guidance about the next steps following completion.

Once Adult Services own assessment (including any Risk Assessments) have been undertaken, it may identify concerns and/or risks that could impact on the service user's ability to care for children and appropriately meet their needs. This should trigger the need for practitioners to complete the Keeping Children Safe Assessment. It will support a practitioner within services for adults to determine whether the difficulties faced by the adult(s) are impacting on their parenting capacity, or raise concerns about the wellbeing or safety of any child in their care, or who they are in contact with. This guidance should be considered in relation to parents or care givers with mental health problems, drug and alcohol use, and where there are concerns about domestic abuse. While the ultimate goals are the safety and well being of the children, consideration of the entire family should also inform interventions.

Practitioners are required to think about the needs of the children in the household or in contact with the service user. It is critically important that we understand the ability of parents or caregivers in ensuring that the child's needs are being appropriately and adequately responded to. The outcomes of the Keeping Children Safe Assessment are intended to inform the practitioner's decision to initiate a referral to Children's Social Care if necessary, or other support agencies.

### The 'Assessment Triangle' - Framework for Assessment<sup>27</sup>

The Framework for the Assessment of Children in Need and their Families is a national framework which clearly demonstrates the factors that need to be taken into consideration to ensure promote the wellbeing and safety of children. This will help you identify any additional needs of the adult to care for children or support your actions with any areas of concern.

It provides a systematic basis for collecting and analysing information to support professional judgements about how to help children and families in the best interests of the child. Practitioners should use the framework to:

- gain an understanding of a parent/adult's capacity to respond appropriately to a child's needs, including their ability to keep the child safe from harm
- Consider the child's developmental needs
- Consider the impact of wider family and environmental factors on the parent and child

<sup>27</sup> See 'Working Together to Safeguard Children' 2015 <http://www.workingtogetheronline.co.uk/chapters/contents.html>



## Family and Environmental Factors

### Family History and Functioning

Family history includes both genetic and psycho-social factors. Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family/household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and its impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

### Wider Family

Who are considered to be members of the wider family by the child and the parents? This includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

### Housing

Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members; this includes the interior and exterior of the accommodation and immediate surroundings.

Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

### Employment

Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child; this includes children's experience of work and its impact on them.

### Income

Is income available over a sustained period of time? Is the family in receipt of all its benefit entitlements? Is there sufficiency of income to meet the family's needs? Consider the way resources available to the family are used. Are there financial difficulties which affect the child?

### Family's Social Integration

Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents. Includes the degree of the family's integration or isolation, their peer groups, friendship and social networks and the importance attached to them.

### Community Resources

Describes all facilities and services in a neighbourhood including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities.

Includes availability, accessibility and standard of resources and impact on the family, including disabled members.

## **Parenting Capacity**

### **Basic Care**

Providing for the child's physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

### **Ensuring Safety**

Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger, and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

### **Emotional Warmth**

Ensuring the child's emotional needs are met and giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

### **Stimulation**

Promoting child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

### **Guidance and Boundaries**

Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries.

This is to enable a child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

### **Stability**

Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver(s) in order to ensure optimal development. This Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

## **Dimensions of Child's Developmental Needs**

### **Health**

Includes growth and development as well as physical and mental wellbeing. The impact of genetic factors and of any impairment needs to be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations (where appropriate) and developmental checks, dental and optical care and, for older children, appropriate advice and information on issues that have an impact on health, including sex education and substance misuse.

### **Education**

Covers all areas of a child's cognitive development which begins from birth. Involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs. Includes opportunities:

- for play and interaction with other children
- to have access to books
- to acquire a range of skills and interests
- to experience success and achievement

### **Emotional and Behavioural Development**

Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family. Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self-control

### **Identity**

Concerns the child's growing sense of self as a separate and valued person. Includes the child's view of self and abilities, self-image and self-esteem, and having a positive sense of individuality, race, religion, age, gender, sexuality and disability may all contribute to this. Feeling of belonging and acceptance by family, peer group, and wider society including other cultural groups.

### **Family and Social Relationships**

Development of empathy and capacity to place self in someone else's shoes. Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

### **Social Presentation**

Concerns child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and availability of advice from parents or caregivers about presentation in different settings.

### **Self Care Skills**

Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. Includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children. Includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self care skills.

### **Mental Health**

When someone becomes mentally unwell, they may find everyday things very difficult to do and they may feel confused and upset a lot of the time. They may do things that seem normal to them, but to other people watching they may seem unusual.

Many children will grow up with a parent who, at some point, will have a mental illness. Most of these parents will have mild or short-lived illnesses, and will usually be treated by their general practitioner. A few children live with a parent who has a severe mental illness such as schizophrenia or bipolar affective disorder.

Many more children live with a parent who has a long-term mental health problem, such as personality disorder, depression or dual diagnosis, and in circumstances where drug and alcohol abuse is a factor. Children often cope well when a parent is ill for a short time. Children do find it difficult to cope when the problem is more long term.

Women are more likely to develop a mental health problem during the peri-natal period (pregnancy and the year following birth) than at any other time in their lives. They are also at greater risk of a relapse during this time if they have a history of mental health problems. Perinatal illnesses can have a negative impact on the baby. For example, babies of anxious mothers may be born with abnormal stress responses. A child in its first year may not be able to form a secure attachment if its mother has been depressed. This can have long term consequences for development.

### **Delusional Ideations and Suicide Planning**

Children who are most likely to suffer significant harm are those featured within parental delusions and children who have become targets for parental aggression or rejection or who are neglected as a result of parental mental illness.

For many children in this situation significant problems can arise where additional family support is required balanced with immediate action. The Keeping Children Safe Assessment would support decision making and trigger a referral to children's services if appropriate.

### **Substance Misuse**

All substance misuse is potentially harmful and most types of use carry health risks. The use of drugs and alcohol can result in accidents, unsociable behaviour, crime and health problems including poisoning or overdose. Use of certain substances, for example, heroin and cocaine/crack is associated with a greater potential to cause harm due to both greater health risks and greater social risks, such as acquisitive crime.

It is acknowledged that not all substance users have problems with parenting. However in many cases it will be necessary to determine whether the substance use and behaviour of the parent is having any impact upon their parenting capacity, before deciding what help, if any, is required. The Keeping Children Safe Assessment may need to be completed to support decision making and trigger a referral to children's services if appropriate.

### **Domestic Abuse**

Domestic abuse not only affects its adult victims, but it also plays a tremendous role on the well-being and developmental growth of children witnessing the violence. Children need a safe and secure home, free of violence, and parents that love and protect them. They need to have a sense of routine and stability, so that when things go wrong in the outside world,

home is a place of comfort, help and support. It is important that when domestic abuse is identified in our adult assessments, consideration is given to the children. Many children are exposed to domestic abuse at home, and this has a powerful and profound impact on their lives and opportunities for the future.

Alcohol/ drug consumption and mental illness can be co-morbid additional challenges when present alongside patterns of domestic abuse within the family. The Keeping Children Safe Assessment may need to be completed to support decision making and trigger a referral to children's services if appropriate.

### **Consent from the Service User**

It is good practice to ensure that service users are fully assisted to understand that information may need to be shared with other agencies to provide additional support. Consent arrangements should cover the need to share information where there concerns about the safety and protection of children and young people. In circumstances where the service user declines consent, consideration should be given to override this decision where there are concerns of significant risk to children. Seek advice from the Safeguarding Children Team.

### **Suggested Ways to Ask Questions**

#### **Family and Environmental Factors**

In your family, what works well?

Is there anything that you think you would like to improve?

At times when there may be difficulties, who provides support to help care for the children?

What might be stopping you from making progress as a family?

#### **Parenting Capacity**

Parenting is not something that you wake up and know how to do...it is hard for all of us. Considering your current situation (alcohol and drug misuse, mental health, domestic violence), is being a parent something you struggle with?

Scaling question—On a scale of 1-10, where are you at in comparison with where would you like to be as a parent? What would you like to change?

Considering the care needs of the children – what support, if any, would you require?

#### **Child's Developmental Needs**

How would you describe your child's progress and growth?

What is one creative way that you have dealt with your child's frustrating behaviour?

If there was an opportunity for further support in your child's development what would you suggest?

Keeping Children Safe Assessment

Does the service user live in a household where there are children?

Check Records                      Yes       No

Please specify relationship :

Where there are children in the household please specify their age if known;

Name of Child	Date of Birth	Gender

Does the Service User have contact with children (not living in the same household) from previous relationships?

Yes                       No

If yes, please specify;

If no and there are children from a previous relationship, is it likely that the contact will be resumed;

Does the service user have significant contact with other children? For example, children within extended family circumstances or children outside the family relationship?

Yes                       No

If yes please specify;

**Family and Environmental Factors**

Does the Service User experience any family and environmental difficulties that could impact on their ability to care for children?

Yes  No

Please use this space to support your assessment outcome. Possible factors: Family Functioning, Wider Family and Relationships, Housing, Employment, Income/Financial Difficulties, Social Integration, Access to Community Resources

**Parenting Capacity**

Consider the outcomes of the Adult Assessment. Can the Service User demonstrate their ability to care for Children or do they require any additional support with parenting?

Yes  No

Please use this space to support your assessment outcome. Indicators: Dependency of Child upon Adult (consider age factors), Ability to provide Basic Care, Ensuring the Safety, Emotional Warmth, Stimulation, Guidance and Boundaries and Stability

**Child Developmental Needs**

Does the information gathered so far suggest that there could be identified difficulties with the child's developmental needs?

Yes  No

Please use this space to support your assessment outcome. Indicators: Potential Poor Health Outcomes, Lack of Education, Emotional and Behavioural Development, Identity, Family and Social Relationships, Social Presentation, Self Care Skills

**Domestic Abuse**

Are there any factors of domestic abuse impacting on any known children? Yes  No

Please use this space to support your assessment outcome. Document what you know.

**Substance Misuse**

Have any concerns been identified in relation to substance misuse? For example, drug and alcohol use that may impact on daily functioning, offending behaviour, the care and wellbeing of children. Is the drug use by the parent: Experimental? Recreational? Chaotic? Dependent?

Yes  No

Please use this space to support your assessment outcome. Indicators: Impact on social, physiological, psychological, and economical factors such as poor mental and physical health, domestic abuse, criminal activity and associated peers

**Mental Health, Delusional Ideations and Suicide Planning**

Does the risk assessment profile indicate delusional beliefs involving children?

Yes  No

Does the risk assessment profile (or any additional risk assessment tools used) indicate suicidal ideation and or a suicide plan involving children?

Yes  No

Are there any other mental health concerns which may impact on the service user's ability to care for children?

Yes  No

Please use this space to support your assessment outcome, taking into account what you know from other risk assessments.

The outcomes of the Keeping Children Safe Assessment will help you to summarise and inform your decision as to whether additional support and services is required. It should also clearly explain the identified risks. The recommendations and actions of the professional completing the Keeping Children Safe Assessment Tool should be determined against the risk/need ratings below<sup>28</sup>. This will assist in identifying the most appropriate referral pathway. In developing this guidance the following outcomes have been determined to identify risks/need:

**Current Risk/Need Status**

**0 = No Apparent Risk/need.** No history or warning signs indicative of risk to children and no apparent additional needs.

**Outcome: No Further Action Required**

**1 = Low Apparent Risk/need.** No current behaviour indicative of risk to children but person's history and/or warning signs indicate the possible presence of risk and additional needs for the children. Necessary levels of screening/vigilance covered by standard current adult support/care plan and ongoing review arrangements. Advice can be sought from the trust Safeguarding Children Team, and where addition needs are apparent a referral may be appropriate.

<sup>28</sup> The numeric score is a simple indicator e.g. Zero (0) is a very low or nil concern, whereas a greater number is an indication of a higher level of concern.

**Outcome: Support within Adult Services with relevant monitoring and identification of additional needs with appropriate referral if required.**

**2 = Significant risk/needs.** Person's history and current presentation indicate the potential of risk to children or the need for additional support and this is considered to be a significant issue. Additional Support should be explored to minimise any risks.

Where **Significant Risk/need** a telephone conversation with Children's Social Care should take place to determine appropriate interventions and course of action to prevent risk escalating and meet additional needs through team around the family. A copy of the Keeping Children Safe assessment Tool should be shared.

**Outcome: Advice should be sought from Children's Social Care to determine appropriate course of action.**

**3 = Serious Apparent Risk.** Circumstances are such that potential risks to children are apparent and referral to Children's Social Care is required.

Where **Serious Apparent Risk** is determined an initial telephone consultation with Children's Social Care should take place and any referral documentation should be completed. The Keeping Children Safe Assessment tool should be shared with the team and the appropriate course of action determined

**Outcome: Contact Children's Social Care and if appropriate support referral with the Keeping Children Safe Assessment.**

**4 = Serious and imminent risk.** The person's history and presentation indicate high need for child protection and the organisations child protection procedures should be implemented. This will result in a referral to children's social care – as a 'child in need' or 'child protection'.

Where **Serious Imminent Risk** is determined. **Immediate action required.**

An initial telephone consultation with the Children's Social Care should take place and any referral documentation should be completed requiring services to follow their own child protection and child in need procedures. The Keeping Children Safe Assessment tool should be shared with the team to support referral and the appropriate course of action determined.

**Outcome: Contact Referral and Assessment Team as high priority and support referral with this Keeping Children Safe Assessment.**

- **Cambridgeshire Children's Social Care**

Telephone - 0345 045 5203. Out-of-hours Emergency Duty Team - 01733 234724.

Fax - 01480 376748

Post: Cambridgeshire Direct, Children's Team, PO Box 14, St Ives, Cambs PE27 9AU

E-mail - [referralcentre.children@cambridgeshire.gcsx.gov.uk](mailto:referralcentre.children@cambridgeshire.gcsx.gov.uk)

- **Peterborough Children's Social Care**

Telephone - 01733 864170/80. Out-of-hours Emergency Duty Team - 01733 234724.

Fax - 0870 2384083

Post: Children's Social Care, Initial Enquiries Referral and Assessment Team (Children & Families), Children's Services, 1st Floor Bayard Place, Broadway, Peterborough, Cambs, PE1 1AY.

E-mail - [cscrecords@peterborough.gcsx.gov.uk](mailto:cscrecords@peterborough.gcsx.gov.uk)

## Appendix G - Decision-Making Flowchart

