Luton Safeguarding Children Board

Bedford Borough Safeguarding Children Board

Joint agency protocol for working with vulnerable families where one or both parents have mental health problems.

Glossary of abbreviations

AOT	Assertive Outreach Team
AMHP	Approved Mental Health Practitioner
ASPA	Assessment and Single Point of Access Team
BBSCB	Bedford Borough Safeguarding Children Board
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CBSCB	Central Bedfordshire Safeguarding Children Board
CIN	Child In Need
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
CP	Child Protection
CPA	Care Plan Approach
CSC	Children Social Care
CSW	Community Support Workers
DCT	Disabled Children's Team
EDT	Emergency Duty Team
LAC	Looked after Children
LSCB	Luton Safeguarding Children Board
MAFS	Multi Agency Family Support Panels
MACC	Multi Agency Child Conferences
MASH	Multi Agency Support Hub (Bedford Borough)
MHAU	Mental Health Assessment Unit
OT	Occupational Therapist
PCT	Primary Care Trust
SEPT	South Essex Partnership Trust

1. Introduction

1.1 A substantial proportion of adults known to the mental health services have children. In common with the population as a whole, most parents with mental health needs are very committed to their children and want what is best for them. To ensure that the needs of both parents and children are met, a high level of joint working and co-operation is essential from both Mental Health services and Children Social Care teams.Working Together to Safeguard Children; A guide to inter-agency working to safeguard & promote the welfare of children March 2013.

” **Indentifies children & families who would benefit from early help.**
Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.

Professionals should, in particular, be alert to the potential need for early help for a child who:

 is disabled and has specific additional needs;

 has special educational needs;

 is a young carer;

 is showing signs of engaging in anti-social or criminal behaviour;

 is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, domestic violence; and/or

 is showing early signs of abuse and/or neglect “

This Protocol aims to provide guidance for Mental Health and Children professionals on working together to provide a seamless service that addresses the needs of families affected by mental health problems.

2. Issues

2.1 Being a parent with a mental health problem is particularly challenging. Many are aware that their disorder affects their children’s well-being even if they do not fully understand the complexities involved.

2.2 All children, even very young children, have a high degree of sensitivity to the environment around them. Thus, their parent’s state of mind will have an impact on them. In this context all children are vulnerable when a parent is suffering from mental health problems. Their own family role may evolve to the point of their being identified as young carers who are entitled to an assessment under the Children Act 1989 and Carers (Recognition and Services) Act 1995 in their own right.

2.3 Children in such families are vulnerable both on account of their parent’s disorder and also because of secondary factors that typically accompany any chronic illness. Examples may be low income, poor housing and neighbourhood, stressed family relationships and societal prejudice. Parents with mental illness have a need to be encouraged and empowered in their parenting without fear of prejudice.

2.4 Their children have a right to have their needs assessed, receive appropriate services and be heard in their own right so that risk factors can be minimised and enabling protective factors promoted. This type of approach should help ensure that children are enabled to achieve their fullest potential and move confidently into adult life.

2.5 All children will benefit from an age-appropriate explanation of their parent's illness, using language that is simple and non-jargonistic. However, except in cases where there are evident safeguarding concerns, the parent's consent should always be actively sought before talking to the children. All attempts should be made to ensure that parents and relatives are actively involved in discussions about why it is helpful for children to have an explanation and information about their parent's illness.

2.6 Adult mental health and drug and alcohol services need to be proactive in helping families to access early support and identifying young people who might be taking on caring responsibilities for parents or siblings. (Ofsted Report March 2013 What about the Children)

2.7 As Part of the Care Programme Approach Adult Mental Health Professionals should routinely make enquiries with respect to dependent children. The assessment should provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties. Consideration should be given to the involvement of partner organisation including Children's Social Care to ensure the needs of the child are identified and supported appropriately. .

2.8 Consideration should be given to joint working to ensure that discharge planning takes account of the needs of the child.

3. Purpose of this Protocol

3.1 Research studies have demonstrated that a family-orientated, holistic and participative approach is the most effective way of ensuring that the needs of parents and children are met as far as is feasibly possible. In this way, the needs of the whole family can be assessed and addressed, with due regard for both the safety and growth potential of both adults and children. Studies have also shown that good outcomes are achieved through effective interagency collaboration and flexible joint working across services and interfaces. Recent Serious Case Review Studies have shown sadly that where this participation is lacking, it has significantly contributed to an increase in what otherwise could have been possibly preventable tragedies. This protocol sets out a framework of best practice for professionals and managers at all levels when working together with these vulnerable families and is consistent with the PAN Bedfordshire's Safeguarding Inter-agency Procedures.

3.2 The main aims of the Protocol are:

- To provide a joint framework of holistic assessment for adults with enduring mental health problems who are also parents or carer, which addresses their needs and those of children, in a way that:
    - Considers the needs and safety of the children.
    - Recognises the needs of the adults both as mental health service users and as parents or carers.
    - Acknowledges and understands the impact of mental illness on parenting and children.
    - Supports family life and positive parenting.
    - Promotes joint and multidisciplinary working across services and organisations.
    - Provides a non-stigmatising service that promotes and encourages social inclusion for all users.

- To improve interagency working practices by setting out details of each agency's referral and assessment procedures, including thresholds and timescales for statutory intervention.
- To provide a framework of quality assurance by outlining the service standards expected from each agency and the procedures for addressing any issues that may arise.
- To improve interagency communication and information sharing through the use of an agreed set of philosophies and policies.

3.3 Scope of the Protocol

This protocol applies to:

- Community mental health professionals working in the Community Mental Health teams.
- Mental Health and Social Care staff based in hospitals.
- Children and Families social workers working in Bedford Borough, Central Bedfordshire & Luton Children Social Care Department.
- All other Professionals working with children and families within Bedford Borough, Central Bedfordshire & Luton.

4. Principles

- Childs welfare and safety is paramount
- Needs led approach
- All professionals involved have a responsibility for the safety and well-being of children
- Promoting child and parent participation
- Valuing and appreciating diversity
- Children are best placed within their families and support should be provided to enable this wherever possible and in the best interests of the child
- Clarity about accountability and responsibility to the child and mentally ill carer
- Parents with a mental health illness have a right to be supported in a non-judgemental approach that enables them to fulfil their parental responsibilities
- Risk is reduced when information is shared in a timely manner
- Children have a right to services that promote their physical, spiritual and emotional health and well being and development so that they can achieve their potential.
- The well-being of children and their families is best served by a multi-agency approach where different services work co-operatively together.

4.1 The principles underpinning this protocol are encompassed in the Department of Health guidance,

Working Together to Safeguard Children 2013 chapter 2 - sections 9-12sets out specific roles applicable to NHS Trust staff working in CAMH services and adult mental health services;

5. Confidentiality and information sharing

5.1 Legal framework

5.1.1 As a general rule, personal information that agencies hold on a client is subject to a duty of confidentiality and cannot be shared with third parties. However, there are circumstances where it is both necessary and/or legal to disclose information. Sharing of information is lawful where:

- The client has consented to disclosure.

- The public interest in safeguarding a child's welfare overrides the need to keep information confidential.
- Disclosure is required under a court order or other legal obligation.

5.2 Disclosure with consent

5.2.1 Individuals can give their consent to personal information about them being disclosed to third parties, but it must be explained why this information is needed and to whom it will be disclosed. If the information is sensitive in nature, for example relating to a person's mental health, such consent would need to be in writing and placed on their case file. Verbal consent should be recorded in the case notes.

5.2.2 A young person aged 16 years or over is capable of giving consent on their own behalf; children under 16 years can only give consent if it is thought that they fully understand the issues and are able to make an informed decision. If not, the decision must be made by the person who holds parental responsibility for them.

5.2.3 Where an adult is deemed incapable of giving consent to disclosure, consent should be sought, where possible, from a person who has the legal authority to act on that person's behalf.

5.2.4 If it is not possible to obtain consent to disclosure, information can be disclosed without consent under the following circumstances:

5.3 Disclosure without consent

5.3.1 Where consent has not been given, or it is thought that to seek consent from a parent or carer may place the child at unacceptable risk, professionals should consider whether it is lawful for them to disclose the information without consent.

5.3.2 Clearly, it would be lawful to disclose information in order to safeguard a child's welfare, but professionals must consider the proportionality of disclosure against non-disclosure: the main question being is the duty of confidentiality overridden by the need to safeguard the child? Where information is disclosed, it should only be relevant information and only disclosed to those professionals who need to know. Professionals should consider the purpose of disclosure and remind those with whom information is shared that it is only to be used for that specified purpose and should otherwise remain confidential.

5.3.3 Further guidance on information sharing with regard to safeguarding children is contained in 'Working together to Safeguard Children 2013 chapter 1 sections 21-25 and in 'Information Sharing; Guidance for practitioners and managers DCSF 2008

6. Role of the Adult Mental Health Teams (ASPA, CMHTs, AOT and CRHT)

6.1 Adults

6.1.1 All of the community teams in the Mental Health Trust are multidisciplinary teams made up of a combination of mental health social workers (MHSW), community mental health nurses (CMHN), community support workers (CSW), occupational therapists, psychologists, psychotherapists and psychiatrists. These teams undertake assessments of mentally disordered adults using the care programme approach (CPA). When a case is allocated in the team, the allocated worker is known as a care co-ordinator. This can be any

qualified professional, depending on the needs of the individual. The CPA care plan and risk assessments are reviewed regularly.

6.2 Referral and assessment procedures

6.2.1 Referrals to Adult Mental Health services primarily come from a patient's GP; however it is possible for other professionals to make referrals. Direct referrals from service users are generally not received; however urgent psychiatric assessment can be accessed through A&E at Bedford and Luton and Dunstable Hospitals.

6.2.2 When an adult who is a parent or carer is referred to mental health services an initial mental health assessment will be undertaken by members of the ASPA team; who aim to assess new patients within 72 hours of receiving the referral. ASPA are able to provide support and treatment for service users for a period of up to 12 weeks. If it is felt that the service user will require ongoing intervention referrals will be made to the CMHT, AOT or any of the other specialist teams within mental health services.

6.2.3 If it is considered that the person referred has needs that do not meet the threshold for longer term intervention and allocation to a secondary mental health service, the ASPA team should consider the safeguarding needs of any children in the patient's family and follow the information-sharing procedures outlined above, in addition to advising on other possible sources of information or support, with normally the person's GP taking the lead on care delivery.

6.2.4 Where an assessment indicates that a service user is in crisis and requires immediate psychiatric assessment and treatment, a referral should be made to the Crisis Resolution Home Treatment (CRHT). Staff in the CRHTs will decide whether the service user could be assisted by a period of intensive home treatment; should be admitted to a bed on the Mental Health Assessment Unit (MHAU) or an acute inpatient bed. In some extreme cases of mental health crisis and high risk the Crisis Resolution and Home Treatment Team may make a referral to the duty AMHP to consider undertaking an assessment under the Mental Health Act (1983)

6.2.5 When an adult is referred to/or accepted by ASPA the health professional making the referral or accepting the referral should enquire if the person has parental responsibilities, is pregnant or has regular contact with children and make routine enquiries. They should note any childcare issues on the appropriate documentation, including:

- Details of who is looking after/caring for the children.
- Any concerns about the care of the children while in the patient care
- Any involvement of other agencies, particularly with Children's Social Care.

Who the other significant others are i.e. with parental responsibility, this is particularly important when the patient has not got 'parental capacity'.

7. Inpatient services

7.1 Admission

7.1.1 When an adult is admitted to an inpatient psychiatric ward, the admitting nurse should enquire if the person has parental responsibilities, is pregnant or has regular contact with children and make routine enquiries. They should note any childcare issues on the appropriate documentation, including:

- Details of who is looking after the children.
- Any concerns about the care of the children while the patient is on the ward.
- Any issues about visiting, taking into account ward policy.
- Issues about parental leave.
- Any involvement of other agencies, particularly with CSC.
- Who the other significant others are i.e. with parental responsibility, this is particularly important when the patient has not got 'parental capacity'.

7.1.2 If, due to the nature of the patient's illness or for any other reason, it is not possible to gather information about the children, this should be sought from other sources available. In the first instance, ward staff should contact the CSC Referral and Assessment Team**Initial/Intake & Assessment team** to see if the family are known, if it is believed that there are children involved. Any gaps in information about a patient's child or children should be noted in the case records and must be followed up with the patient, their relatives or other professionals involved, for example the GP or health visitor, within five days of admission.

7.2 Patient known to Children and Families

7.2.1 Where a patient is known to CSC, then CSC should be:

- Informed about admission as soon as practicable.
- Where possible given advance notice about hospital leave.
- Informed if the patient is absent without leave.
- Involved in planning for the patient's discharge.
- Informed if the patient's discharge is imminent, whether or not joint planning has been possible.
- Invited to the formal discharge meeting

7.2.2 Information must be left with the patient's children social worker, the duty worker or the relevant administrative officer and a record made of the person spoken to.

7.2.3 Out of normal office hours, urgent information should be passed to the emergency duty social worker available on 0300 3008123. This should then be communicated to the relevant duty team the next working day.

7.2.4 If CSC are involved with a patient, or accept a referral, they should be invited to all care planning meetings under the CPA.

7.2.5 If the patient does not agree to the children social worker being invited to their CPA meeting, the ward manager or senior nurse will discuss the patient's objections with them and explain the importance of professionals working together for the benefit of themselves and their children. It may be possible to arrange for the children social worker or another children's worker to attend part of the meeting.

7.2.6 Where there are issues about children's welfare, discharge plans must involve and be agreed by all professionals working with the family. Copies of plans must be filed in both adult CMHT and CSC files.

7.3 Patient not known to Children and Families

7.3.1 If the patient and their family are not known to CSC, the patient's care co-ordinator in the CMHT should be informed as soon as possible. They will refer the family to CSC or other services as deemed appropriate.

7.3.2 If there is no care co-ordinator or the care co-ordinator is not available and the situation is urgent, the admitting or primary nurse must consult the ward manager, senior nurse of the Named Professional for Safeguarding Children. They will decide if a referral to CSC is required following safeguarding procedures, if the child is considered to be at risk of significant harm.

7.3.3 If there are no significant harm concerns then a referral to CSC will require the agreement of the patient or other person with parental responsibility.

8. Children

8.1 Mental health professionals have a duty to promote the well-being of children and safeguard them from harm. In so doing, Mental health professionals should routinely record the names and dates of birth of any children within the household of a service user, or of any children the user has parental responsibility or regular contact with and clarify whether the child/ren are a carer for their parent or other siblings due to their parents health issues. If possible, they should also record the names of the children's schools, their GP and any other health or social care professionals involved with the children or their family.

8.2 Criteria for child referrals

8.2.1 Where any of the following are present in an adult parent/carer a referral should be made to Children Social Care for an assessment or a CAF can also be considered here to be carried out in order to determine how the needs of the child can be met and the likelihood of significant harm. Threshold criteria is available in LSCB procedures but might include:

- Delusional thinking involving the child
- Self-harming behaviour and suicide attempts; particularly when the child is at risk as part of any suicide plans
- Altered states of consciousness e.g. splitting/dissociation, misuse of drugs, alcohol, medication
- Obsessive 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
- Disorder designated 'untreatable', either totally or within timescales compatible with the child's best interests
- Domestic abuse and/or relationship difficulties
- Unsupported and/or isolated parents
- A child is acting as a young carer for a parent or sibling

8.2.2 The threshold for significant harm is likely to have been reached when:

- There is an impact on the child's growth, development behaviour and/or mental/physical health.
- The parent/carer's needs or illnesses are taking precedence over the child's needs.
- There is insufficient alternative care for the child within the extended family.

8.2.3 Factors associated with positive outcomes for children where a parent has a mental illness are:

- Mild parental problems lasting only a short time.
- Minimal family disharmony and stability in family relationships.
- One parent or family member able to respond to the child's needs.

8.2.4 Children most at risk of significant harm are those:

- Who feature within parental delusions
- Who might be harmed as part of their parent's suicide plan
- Who become targets for parental aggression or rejection
- Who are neglected as a result of parental mental illness
- Where mental illness is combined with domestic abuse

Safeguarding Children Board's Safeguarding Inter-Agency Procedures (2006)
NPSA Rapid Response Report - Preventing harm to children from parents with mental health needs (2009)

8.2.5 The Biennial Analysis of Serious Case Reviews, New learning from serious case reviews a two year report for 2009-2011. Highlights that in 58% of the cases parental mental ill health was a significant risk factor. With further evidence that in about two-thirds of the cases featured domestic abuse, and mental ill health of one or both parents.

8.2.6 The following table may assist in the assessment process:

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

8.2.7 If it is believed that the child would benefit from family support services, and the child is not at risk of significant harm then professionals may refer, but only with the consent of the person with parental responsibility.

8.2.8 Professionals can refer to appendix B of this protocol for guidance on what level of needs a child has and what appropriate action should be taken. Level two is borderline 'child in need'; some children will be eligible for a service, others may be referred to other agencies. Children who exhibit needs at level three must be referred to CSC as statutory intervention may be required.

8.2.9 Adult services may consider a referral to the Multi Agency Family Support Panels (**MAFS - Luton**) **or Multi Agency Child Conferences (MACC - Central Bedfordshire) Local Network Panels - Luton** if appropriate for level 2 cases that do not meet social care criteria.

9. Referring to Children Social Care

9.1 If a mental health professional has concerns about the safety of a child they should speak to their manager or other lead professional (i.e. named Professional for Safeguarding Children) and make an immediate referral to the MASH/Referral and Assessment**Initial/Intake** Assessment team. **The referral should be followed up in writing within 24 hours, please refer to Appendix A in regards to how this should be done to Bedford Borough, Central Bedfordshire & Luton Children Social Care.** The parent or carer should be informed of the referral unless there are concerns, for example, if the child protection investigation or the future safety of the child could be compromised.

9.2 If there is no immediate risk but there are concerns that the child's needs are not being met, the mental health professional should check whether the child or family is known to CSC. Mental health professionals should also check with the CAF administrator to see if a CAF has been completed and if so who the lead professional is. If they are not known, the child should be referred by telephone, with the permission of the person who has parental responsibility, to the CSC MASH/Referral and Assessment**Initial/Intake & Assessment team**, followed by a referral in writing within 48 hours.

9.3 If the decision is made by CSC to undertake an Initial and/or Core Assessment then there needs to be some agreement/decision as to whether this is a joint assessment as the issues around the parent/carers ability to meet the needs of the child/ren will need to be assessed taking into account their mental health problems. CSC workers are not experts in this field and therefore the cooperation and expert input of CMHT workers is essential.

9.4 If the situation is considered by CSC to be below the threshold for a service (see appendix 2 for details of thresholds), they will advise on other services available, a CAF) **or Multi Agency Child Conferences (MACC - Bedford Borough & Central Bedfordshire)** Local Network Panel (LNP Bedford Borough) may be appropriate. See appendix A for contact details.

9.5 If there is no immediate risk to the child, and the person with parental responsibility is in agreement, the mental health professional can refer the children or family directly to other services for children such as the Young Carers Project, CAMHS.

10. Role of Children's Social Care

10.1 Children

The lead agency for children is the Children Social Care Department of the local Authority.

10.2 Referral and assessment procedures

10.2.1 When a referral meets the threshold for CSC a single assessment will be undertaken. This must be completed within 45 working days of the referral being received. The assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action (e.g. S47 enquiries) needs to be taken by the social worker to ensure the child's safety. In this case the mental health professional should be fully informed and be involved in any child protection strategy discussion or meeting.

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10.3 Adults

10.3.1 Children social workers should routinely record whether a parent has a mental health problem and who is treating this. If the adult does not meet the threshold of the CMHT, then their GP can be contacted for advice.

10.4 Referral to Community Mental Health Services

10.4.1 If a children social worker has concerns about a parent's mental health, they should check whether the adult is known to the Mental Health Trust. See appendix A for contact details.

10.4.2 All referrals should be made by phone to the relevant ASPA team depending on the parent's address.

10.4.3 If an adult with mental health issues is at imminent risk to themselves or others consideration should be given to contacting the police and their care co-ordinator should then be contacted.

10.4.4 If they do not have a care co-ordinator or the care co-ordinator cannot be contacted, the person should be referred to the duty Approved Mental Health Practitioner service (AMHP) who will assess the situation and act accordingly. The AMHP service can be reached via the adult duty system. If possible, the person's GP should be contacted for advice.

10.4.5 In non-urgent cases the GP can make a referral to the Assessment and Single Point of Access (ASPA) Team, as detailed earlier in this protocol.

10.4.6 When making a referral the GP should enquire if the person has parental responsibilities, is pregnant or has regular contact with children and make routine enquiries. They should note any childcare issues on the appropriate referral documentation and reciprocal relationships on the client's medical records, including:

- Details of who looks after/cares for the children.
- Any concerns about the care of the children while in the client's care
- Any involvement of other agencies, particularly with CSC.

Who the other significant others are i.e. with parental responsibility, this is particularly important when the patient has not got 'parental capacity'.

11. Procedures for joint working

11.1 In situations where both CSC and the mental health Trust continue to have an ongoing involvement with a family or are carrying out a joint assessment of the parent, the parent's mental health professional and the child's social worker must be invited to all meetings and reviews that are held by each of the services.

11.2 Throughout the assessment process, there must be:

- Clear communication between the services.
- Sharing of individual assessments.
- Joint planning for ongoing work and services that is recorded in the files of both services.
- A clear indication, recorded on the case files, as to how, when and by whom the plan will be reviewed.
- Sharing of information with the parents or carers, unless this would place the child (ren) at risk or compromise child protection enquiries.

11.3 No major decisions (such as the removal of children, closure of case or move to discharge from hospital) should be made without the consultation of other services, unless urgency requires immediate action. In these circumstances other services should be informed as soon as possible.

11.4 The mental health worker must be informed if a child is returning home following a period of being in care or of accommodation and the children social worker must be informed of any changes in treatment, such as a trial on reduced or no medication.

11.5 If the parent does not agree to the children social worker being invited to their CPA meeting, the care co-ordinator will discuss with the patient their objections and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the Children social worker or another children's worker to attend part of the meeting. It should be recognised that parents may need to discuss confidential information with their doctor which is not relevant to safeguarding children.

11.6 Consideration should be given to inviting the health visitor to all CPA meetings where the service user has a child under five years', or a School Nurse for a child over 5 whether or not the child is known to Children Social Care. In this scenario the parent's consent must be sought at all times.

11.5.7 Whether or not child care professionals attend the CPA where there are concerns about the well-being of the children, the need to share information takes precedence over the patient's right to confidentiality. See pages 4-5 on confidentiality and information sharing.

11.5.8 Written documentation or minutes must be sent to all professionals involved and put on the respective case files.

11.5.9 Regular communication by telephone, fax, email or letter should be maintained, particularly if there are any concerns or changes in the situation.

11.5.10 Where appropriate and practical it is good practice to arrange joint visits from time to time. Otherwise, agencies should co-ordinate visits from CMHTS and CSC to ensure families are seen regularly. In some circumstances it will be appropriate for a service to provide input, and for other agencies to provide consultation.

11.5.11 If any service plans to close a case, the other services must be informed in writing as soon as the decision has been made, outlining the reasons and the alternative support systems in place.

12. Finance

12.1 The appropriate financial procedures for each service must be followed.

12.2 Where additional financial resources are required, the circumstances of the whole family must be addressed and consideration given to using Section 17 monies under the Children Act 1989 or the Fair Access to Care Services procedure or both. Consideration should be given to the consequences of not providing the service. The needs of the parent and children should be clearly identified in planning/discharge meetings so that appropriate packages of support can be costed and agreed, where appropriate.

12.3 In some circumstances, it will be clear one or other service will have the financial responsibility, or there may be an agreement to apportion costs.

13. Resolution of disputes and differences

13.1 The aim of this protocol is to encourage decisions to be taken jointly and to ensure that the needs of both the children and the mental health service user are addressed within the framework of legislation and codes of practice.

13.2 In the event of a dispute or disagreement arising between professionals, in the first instance the matter should be discussed between the respective line managers. If the differences cannot be resolved at this level within a reasonable timescale, then the matter should be referred to the Head of Intake/Assessment and Family Support for CSC and the Associate Locality Director who oversees the CMHT.

13.3 Any disputes involving cases where there is a possible risk to a child should be addressed using the Escalation Procedures which can be found at http://bedfordscb.proceduresonline.com/chapters/p_reolution_disagree.htmlAny disagreements or differences should be recorded on the case file, including the stated views of the other party.

14. Training

14.1 All Professionals dealing with children and families are expected to undertake Safeguarding training as appropriate to their job description.

14.2 Working Together to Safeguard Children 2013 states that “All staff working in healthcare settings - including those who predominantly treat adults - should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance

14.3 Safeguarding Children and Young People: roles and competences for health care staff, RCPCH (2014) provides additional information with respect to health professionals’ training needs.

14.4 Both mental health professionals and children social workers should endeavour to attend all relevant joint training events. These events will encourage an understanding of each agency and working practices, which in turn will help to promote positive interagency working.

Appendix A

Contact Details

Luton Children Social Care
Referral and Assessment Team
Unity House
111 Stuart Street

Luton
Beds
01582 547815/6/7
Out of working hours: Emergency Duty Team 0300 300 8123

To make a referral please use the Child Protection Referral Form available on the LSCB website at Luton.gov.uk/safeguarding children.

Bedford Borough

You can contact the MASH (Multi Agency Support Hub) using the Enquiry Form found at the following link http://www.bedford.gov.uk/health_and_social_care/children__young_people/safeguarding_children_board/idoc.ashx?docid=72616c84-5f8e-4fde-ad16-57c019f8b905&version=-1. This form should be used to make enquires to the MASH on any issue relating to the safeguarding of children and young people. The form should be sent to multiagency@bedford.gov.uk or mash@bedford.gcsx.gov.uk.

Early help assessments should still be completed on the Common Assessment Framework paperwork http://www.bedford.gov.uk/health_and_social_care/children__young_people/safeguarding_children_board/professionals/idoc.ashx?docid=69b83fe2-164c-4cf5-a449-44980b3c372c&version=-1 and emailed to the addresses above.

If your concern is of an immediate safeguarding nature then please contact MASH on 01234 718700 during office hours (08:45 - 17:20 Monday to Thursday; 08:45 - 16:20 on a Friday.

If your referral is of an urgent safeguarding nature and it is out of office hours please call the Emergency Duty Team (EDT) on 0300 300 8123.

Central Bedfordshire Children Social Care
Intake & Assessment Team
Children's Specialist Services
Central Bedfordshire Offices (DC1)
High Street North
Dunstable
Beds LU6 1LF
0300 300 4749 or 4750
Fax Number: 0300 300 8225, please ensure that it is marked urgent and Confidential
Email: Intake&Assessment@Centralbedfordshire.gov.uk.
Out of working hours: Emergency Duty Team 0300 300 8123
CAF Information access www.bedfordshirelscb.org.uk
MACC Information access www.bedfordshirelscb.org.uk

To make a referral to Central Bedfordshire Children Social Care please use the Children's Social Care Referral Form (from 1st September 2010) via Intake and Assessment which can be found at www.bedfordshirelscb.gov.uk (CAF/MAAG section).

Mental Health Services

Mental Health Assessment Units (MHAU)

Bedford

Weller Wing

Mental Health Assessment Unit

Bedford Hospital

Kempston Road

Bedford Beds

MK42 0DJ

Tel; 01234 299955

Luton

Jade ward

Mental Health Assessment Unit

Luton & Central Bedfordshire Mental Health unit

Off Calnwood road

Luton Beds

LU4 0FB

Tele 01582 709180

~~Tele~~

Community Mental HealthTeams
Bedford

Bedford Assessment & Single Point of Access (ASPA)
Weller Wing
Ampthill Road
Bedford
Beds, MK42 9DJ

Tel; 01234 310555

Bedford Recovery
Twinwoods Health Resource Centre
Milton Road
Clapham
Beds, MK41 6AT
Tel; 01234 315785

South Bedfordshire

Dunstable CMHT
Beacon House
5 Regent Street
Dunstable
Beds, LU6 1LP
Tel; 01582 709200

Leighton Buzzard CMHT
Crombie House
36 Hockcliffe Street
Leighton Buzzard
Beds, LU7 1HJ
Tel;
01525 751133

Central Bedfordshire

Ampthill CMHT
Meadow Lodge
Steppingley Hospital
Ampthill Road
Steppingley
Beds, MK45 1AB
Tel; 01525 758400

Biggleswade CMHT
Spring House
Biggleswade Hospital
Potton Road
Biggleswade
Beds, SG18 0EJ
Tel; 01767 224922

Luton

Luton East CMHT
Charter House
Alma Street
Luton
Beds, LU1 2PJ

Tel;01582 709152

Assertive Outreach Teams

Bedford

Bedford assertive Outreach
Florence Ball House
Bedford Health Village
3 Kimbolton Road
Bedford
MK40 2NT
Tel; 01234 315835

Central/South Bedfordshire

South Bedfordshire Assertive Outreach
Crombie House
36 Hockliffe Street
Leighton Buzzard
Bedfordshire LU7 1HJ
Tel; 01525 751133

Luton

Luton Assertive Outreach Team
Charter House
Alma Street Luton
Bedfordshire
LU1 2PJ
Tel; 01582 538647

CAF Team

Prevention & Early Intervention

Children's Services

Futures House

The Moakes

Marsh Farm

Luton

LU3 3QB

Tel: 01582 548321

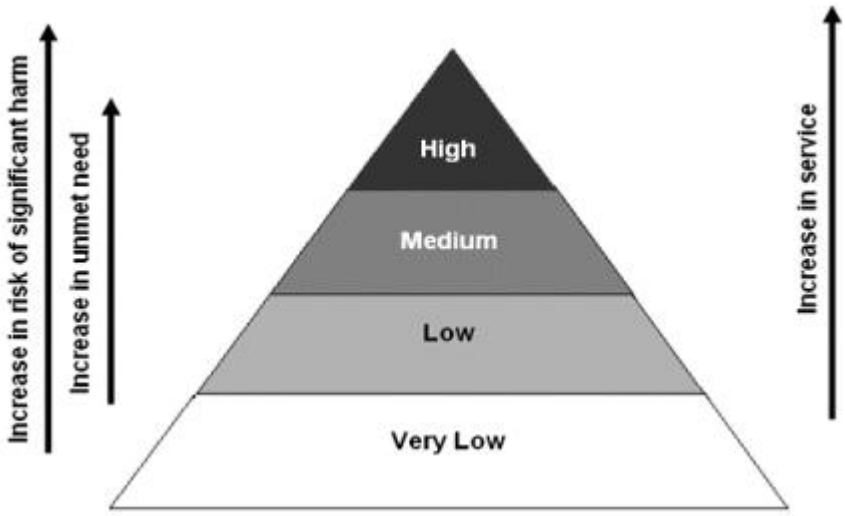
Email: caf@luton.gov.uk

Appendix B

Thresholds for Intervention

We have adopted four levels of priority based on Hardiker et al levels of intervention described in Policies and Practices in preventative childcare 1991 Avebury/Gower. This is for CSC involvement so it does not mean that other services may be appropriate/available at the low/very low – accessible via MAFS/MAAG.

Pyramid of Need



‘Very Low’:

- Children from families where there are difficulties that can be more appropriately addressed by universal services.
- Children whose health and development is not being adversely affected.

‘Low’

- Children from families where carer(s) are experiencing difficulties which may affect the child’s health or development.
- Children whose health and development may be affected.
- Children that fall within the definition of ‘In Need’.
- Children and families where there is a risk of deterioration and the child’s health or development may be affected in the near future.

‘Medium’:

- Children whose health and development is or may be impaired.

‘High’:

- Children experiencing significant harm or where there is a likelihood of significant harm. Children at risk of removal from home

Considering the welfare of children whose parents have mental health needs.
Practice guidance for Adult Mental Health practitioners and all other professionals working with children

Principles

- Children whose parents have severe and/or on going mental health needs will usually be children in need in their own right. As part of the assessment of an adult with mental health problems practitioners need to consider how the adult's illness impacts on their children or those children with whom they have regular contact.
- By law the welfare of the child is paramount – this means that children's needs override those of the adult and that the welfare principle enshrined in the Children Act 1989 takes precedence over the Mental Health Act 1983 in all events.

Assessment Stage

Adult Practitioners will consider

- Who is in the family? (include age, gender, full names of dependent children)
- Does the child have special needs?
- Does the client have parental responsibility?
- What symptoms and behaviours does the adult exhibit and is the impact of these be on the children when acute/when chronic
- What other adults are involved in parenting?
- Is the client pregnant?
- Is the family known to children services (CAMHS/Social Care) if so what is the current involvement?
- Are there any previous/current concerns and do these relate specifically to mental health illness in the parent?
- Does the client have insight and willingness to accept support/services?
- Discuss with the client the availability of support for their parenting role from family or other services e.g. health visitor, CAMHS, Social Care, Parental Mental Health Service

If other children's services are involved

- Discuss with the client inviting key staff from other services to CPA meetings e.g. CAMHS, Health Visitors, Children Social Care
- Discuss with the client liaison/communication with those professionals outside of the CPA process

What to do

If you have no concerns for the child/ren

- Record
- Include parental issues in care plan at every review

If you have minor concerns for the child/ren which are not shared by the adult client, incl. pregnancy

- Discuss with your line manager and agree plan
- Informal discussion with Children Social Care and/or Parental mental health service to decide whether to make a referral and the level of urgency.
- If appropriate, discuss with client
- If concerns are shared by others and risks are posed to the child then refer without clients agreement
- In most instances, the client should be informed of the referral even if it is not with their consent as long as it does not place the child at further risk.

If you have major concerns about the welfare and safety of the child/ren

- Discuss with manager/supervisor
- Seek advice from the Trust-named nurse or Designated Doctor Safeguarding Children if you are not sure
- Refer to Children Social Care
- Agree with Children Social Care when and how to inform the client that a referral has been made

For Adults in Crisis

If the adult is admitted

- Consider how the impact on children can be minimised e.g. agree how contact can be maintained, what support and information the other carer and children need; who will explain the situation to the children and how.
- Discuss with Children Social Care as early as possible when it has been identified that admission may be required
- Ensure written information on the children and arrangements for their care is passed to Ward staff and all other children involved with the children and there is ongoing communication between all professionals and services involved
- As part of discharge planning, ensure support for the parenting role is included and appropriate professionals working with the children are invited to the discharge meeting or have the opportunity to contribute to the plan

If the parent is being looked after at home

- If the child remains at home, it must be remembered that the welfare of the child is paramount
- Ensure there is ongoing communication between all professionals and services involved
- As part of discharge planning, ensure support for the parenting role is included
- The safety and welfare of the child should be kept under constant review and consideration should be given to involving Children Social Care