



PAN DORSET INTER-AGENCY SAFEGUARDING PROCEDURES

CHAPTER 3

3.8 JOINT MENTAL HEALTH, SUBSTANCE MISUSE AND CHILDCARE PROTOCOL

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Safeguarding children whose parents/carers have mental health needs or who use drugs/alcohol

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Safeguarding children whose parents/carers have mental health needs or who may use drugs/alcohol

1 Part One: Introduction (applicable to both mental health and substance misuse)

1.1 Purpose

- 1.1.1 - To safeguard and promote the welfare of children and young people (including young carers) whose lives are affected by parents/carers using drugs/alcohol or by parents/carers with mental health needs;
- To promote effective communication between drugs/alcohol, mental health, primary health care and children's services;
- To promote the concept of '*Safeguarding Families*' recognising that by the nature of Mental Health and Substance Misuse problems, both adults and children may potentially become vulnerable and require services to promote the welfare of whole family.
- To set out good practice for the services involved to encourage working together in the assessment and care planning for families with problematic substance use and/ or mental health needs to enable their full participation in the process wherever possible.

NB In the context of this protocol 'parent' includes anyone who has care of the child, for example, members of the extended family.

1.2 Scope

- 1.2.1 These guidelines apply to and have been written for use by the many statutory, non-statutory, voluntary, independent sector and primary care services working with parents/carers with mental health and/or drug/alcohol problems within Dorset.
- 1.2.2 All practitioners will be expected to use this protocol when they come into contact with:
- an adult with drug/alcohol or mental health issues who is caring for, or has significant contact with, a child.
 - a child whose life is affected by a parent or carer's use of drugs/alcohol or mental health needs.

NB Practitioners working with adults should identify at an early stage the adult's relationship with any children and apply the principles outlined within this guidance and any other locally derived protocols or procedures which support the delivery of this section.

- 1.2.3 All other services represented on the DSCB will be expected to know of the existence of this protocol and be able to recognise when it should be used.

1.3 Background

- 1.3.1 Local authorities have specific duties under the Children Act 1989 in respect of children in need (Section 17) and children at risk of significant harm (Section 47). Those working with adults and children with substance use/misuse and mental health needs in all health, social care and voluntary sector settings have a responsibility to safeguard children when they become aware of or identify a child at risk of harm, following Local Safeguarding Children Board (LSCB) procedures which are based on the Government Guidance *Working Together to Safeguard Children (WT)* (2010).
- 1.3.2 *Working Together (WT)* (2010) outline that “Children need to feel loved and valued and be supported by a network of reliable and affectionate relationships. If they are denied the opportunity and support they need to achieve these outcomes, children are at increased risk not only of an impoverished childhood, but also of disadvantage and social exclusion in adulthood. Abuse and neglect pose particular problems (*WT* section 1.3).
- 1.3.3 Patterns of family life vary and there is no one perfect way to bring up children. Good parenting involves caring for the children’s basic needs, keeping them safe, showing them warmth and love and providing stimulation needed for their development and to help them achieve their potential, within a stable environment where they experience consistent guidance and boundaries” (section 1.4).
- 1.3.3 The government guidance *Working Together* (2010), places the responsibility for the safety and welfare of children with the local authority (*WT* section 2.18), but expects *all* health professionals working with children to ensure that safeguarding and the welfare of children is an integrated part of the care they offer. There is an expectation that health professionals that come into contact with children, parents and carers in the course of their work are aware of their responsibilities to safeguard and promote the welfare of children and young people (*WT* sections 2.67 to 2.77). The same expectation relates to those working in the field of substance misuse (*WT* sections 2.102-2.207).
- 1.3.5 All agencies involved in the care of such adults or children are expected to work closely together, share information and thoroughly assess to promote the welfare of a child or to protect a child from significant harm.
- 1.3.6 Although not addressed within this protocol the impact of Domestic Violence also needs to be considered, as this may be a factor which professionals working with adults who misuse substances or who have mental health issues, will need to assess and identify the risks to both the children and adults involved. (Ref LSCB DV Protocol)
- 1.3.7 *Working Together (WT 2010)* states "Domestic Violence rarely exists in isolation. Many parents also misuse drugs or alcohol, experience poor physical and mental health and have a history of poor childhood experiences themselves. The co-morbidity of issues compounds the difficulties parents experience in meeting the needs of their children, and increases the likelihood that the child will experience abuse and /or neglect." (*WT* 9.19)
- 1.3.8 Building on former publications around Hidden Harm (2003) and (2006), aiming to address the impact of substance use on children and young people, Think Family guidance: DCSF, DH and NTA joint guidance for adult, children's, and drug and alcohol treatment services <http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/ig00637/> was published during the Autumn of 2009 requiring Drug and Alcohol Action Team partnerships to have in place joint protocols addressing parenting and substance use. For Dorset, Bournemouth and Poole, this has constituted a review and revision to the previous version of Section 3.8 which is this document. The Department for Education and the National Treatment Agency for substance misuse are monitoring progress made by partnerships.

1.4 Equality and Diversity

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

1.5 Confidentiality and Sharing Information

- 1.5.1 Confidentiality can never be an absolute principle and it is generally accepted that where children need protecting, their needs are paramount and information may be shared without their parents'/carers' permission. It is critical that **all practitioners** working with adults, children and young people are in no doubt that where they have reasonable cause to suspect that a child or young person may be suffering significant harm or **may be at risk of suffering significant harm**, they should always consider referring their concerns to social care. Practitioners should seek to discuss any concerns with the family and, where possible, seek their agreement to making referrals to children's social care.

This should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm. The child's interest must be the overriding consideration in making any such decisions.

Where a child is not suffering significant harm, parental permission is still needed for the sharing of information. This should be raised with parents at the beginning of professional involvement following agency guidelines, with emphasis on the help and support which can be accessed by the family as a result of sharing information with other agencies. In the process of finding out what is happening to the child, it is important to take into consideration their wishes and feelings.

The Overarching Information Sharing Protocol (OISP) for the Pan-Dorset area and other Information Sharing Protocols may also give a framework to support this.

- 1.5.2 Each agency/organisation will have its own system with regards to undertaking an assessment using the Common Assessment Framework (CAF). Parents should be asked if one has already been done and if so, it will mean that they have agreed to information being shared.
- 1.5.3 Practitioners should be aware of any protection plan around family members e.g. MAPPA, Child Protection Plans, MARAC, and identify the need to be involved in those processes. These should be clearly documented with in the adults or child's records.

- 1.5.4 Practitioners should always be mindful of Risk and any Risk Assessment process and documentation should always be continually reviewed and updated to ensure that the information is always current and live.

1.6 Children's Services

- 1.6.1 Children's Services will, throughout their involvement:

- employ a policy of openness with families where information from other agencies impacts on planning for the child.
- seek consent from family members to share information with other agencies in the best interests of the child (but bear in mind this should only be done if the discussion and agreement-seeking will not place a child at increased risk of significant harm - see *Working Together to Safeguard Children* 2010 Para 5.18)
- be clear whether an assessment using the Common Assessment Framework (CAF) has been or needs to be undertaken and, if so, what the outcomes were/are.
- assess the unborn child's needs and identify desired outcomes for the child.
- assess the child's needs and identify desired outcomes for the child.
- provide a child-focused service to families with whom they are involved.
- ensure that the wishes and feelings of child/ren are ascertained.
- ensure the child is given the opportunity to be seen/heard on their own.
- check with Substance Misuse teams where parents are using drugs particularly where there is an unborn or very young child and make sure that the assessment to include both partners, not just the mother. Risk Assessment documentation must be kept up to date and monitored at regular intervals to ensure risk information is *live* and current
- consult with primary and secondary mental health services and with Substance Misuse teams where applicable for information to support assessment of parenting capacity, and for realistic assessment of any risk even where there are no apparent safeguarding issues, undertaking joint assessment where possible.
- invite representatives from mental health and substance misuse services to Child Protection Conferences where they are involved with the family with the maximum timescales as possible to facilitate attendance and provide reports.
- provide a representative to attend Care Programme Approach meetings where at all possible.
- share assessments, verbally and in writing, with parents and, with parental permission, practitioners working in mental health and/or drugs and alcohol teams.
- identify and address any caring responsibilities a child or young person is undertaking with the parent/carer.
- together with relevant agencies, identify roles and responsibilities for any ongoing work with the family: a meeting is preferable where decisions need to be made and owned.

1.7 Adult Services

- 1.7.1 Parental mental health needs/substance misuse do not automatically indicate that their child is at risk of abuse or neglect, although it is necessary for workers to recognise that these issues can impact on their ability to parent and therefore, this is where an assessment needs to focus.
- 1.7.2 Adult Services will, throughout their involvement ensure that when assessing adults needs that any support parents or individuals with parental responsibility may need with parenting is taken into account.
- 1.7.3 Local authorities are also the lead agency for safeguarding adults.

Services do not always neatly divide into those for adults and those for children, and there will be circumstances when adult services can make a contribution to the safeguarding of children and circumstances when staff in adult services may be aware of the risk of harm to children which should be disclosed, and vice versa.

There will also be circumstances when safeguarding children and adults can and should be done jointly as part of addressing the needs of the Family. For all these reasons children and adult services should be aware of each other's roles and responsibilities, underpinned with effective communication.

Services and workforce planning should take account of the family and neighbourhood context in which safeguarding work is carried out.

extracted from Working Together 2010 Section 2.28

- 1.7.4 The sharing of information between adult and children's services is of paramount importance, particularly when there are children involved who potentially are at risk of significant harm through adult behaviour.

1.8 Young Carers

- 1.8.1 For services to provide effective support for young carers and their families, it is vital that all members of staff working with them begin with an inclusive, wide-ranging and holistic approach that considers the needs of:
 - The adult or child in need of personal care
 - The child who may be caring and
 - The family
- 1.8.2 Children Act 2004 – Young Carers are an “at risk” group and need support.
- 1.8.3 Carers (Equal Opportunities) Act 2004 - Identification of young carers can be problematic. Many children live with family members with stigmatized conditions such as mental illness or/and drug and alcohol problems. In many cases, families fear what professional intervention may lead to if they are identified. Some families may also have concerns about stigmatisation of being assessed under children's legislation
- 1.8.4 Carers (Recognition and Services) Act 1995 – young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring.
- 1.8.5 Under Section 17 of the Children Act 1989, a young carer may be regarded as a child in

need if “he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development”.

- 1.8.6 Carers and Disabled Children Act 2000 – assessments of need must be given when requested by people of 16+ who are in a caring role.
- 1.8.7 The Children’s Plan (DfES 2007) states that: for young carers – services should adopt a *whole family* approach. This means that children’s and adult services must have arrangements in place to ensure that no young person’s life is unnecessarily restricted because they are providing significant care to an adult with an identifiable community care need.
- 1.8.8 In a system that ‘Thinks Family’, both adults’ and children’s services join up around the needs of the family and sets out what this system would look like to families on the ground. Where young people take on caring roles, work to ensure, they receive adequate support and services that safeguard their childhood and aspirations as children and young people.
- 1.8.9 Young carers, parents and their families: Key Principles of Practice (Frank, McLarnon, 2008) are a vital resource for policy makers and practitioners when developing and providing services and can be used to measure success across departments and agencies. The Whole Family pathway (Leadbitter 2008) is a free online resource which will help practitioners achieve the Key principles of practice and promote whole family working.

1.9 Child Protection Conferences

- 1.9.1 Child Protection Conferences will be conducted in line with LSCB child protection procedures. It is expected that representatives from the appropriate statutory and voluntary agencies will attend, and if they cannot, that they will provide the conference with a written report or send a well briefed representative to speak to the report.
- 1.9.2 Parents are encouraged to attend conferences. They may be excluded however, if they are under the influence of substances at the time of the conference to such an extent that they are unable to participate effectively.
- 1.9.3 They are invited to bring someone to support them or an advocate to the conference. Their worker from the Drug/Alcohol Service will always be invited to attend by the social worker. They will be part of the professional network and will be expected to contribute to the decision making.
- 1.9.4 If a decision is made that a child protection plan is required, this will be followed by the development of such a plan including the establishment of a core group. It is necessary for members of this group to be clear about their role and that of others.

1.10 Case Management

- 1.10.1 Effective inter-agency communication and multi-agency co-operation is **crucial** to the management of on-going work with people with mental health needs/substance users and their families. When workers receive new information that is likely to affect a previous assessment of the impact on mental health/substance use problems upon parenting, they must pass this information on to the other agencies involved, so that, if necessary, a reassessment of the situation can be undertaken. It may be necessary to arrange a meeting of professionals to discuss the new information and how it will impact on the family/ies. There must be clarity with regard to the different roles and responsibilities undertaken by different workers and a decision made regarding coordination, so that this is not left to the parent.

Where a child is the subject of a child protection plan, or is identified as a child in need, it is important to maintain a continuous dialogue between Primary Care, Mental Health Services/Drug/Alcohol Services and Children's Services Teams regarding treatment objectives. Professionals working directly with such families are expected to participate in child protection core groups, where these are set up to monitor the progress of Child Protection Plans, and to be clear about their role and responsibility.

1.11 Supervision

- 1.11.1 It is crucial that all agencies establish a clear framework for supervision as staff need to feel, and be properly supported to make their safeguarding practice effective. Those supervising staff working with adults should always ask about the care of children in the family and vice versa. Those managing child care cases should always ask about collaboration with adult workers if there are substance misuse or mental health issues affecting parents.

1.12 Training

- 1.12.1 All professionals who have substantial involvement with children, and pregnant substance users **and their partners** should receive basic awareness training on mental health and substance misuse issues as they relate to safeguarding children, and ways to access resources.
- 1.12.2 **Voluntary organisations have an important role to play in offering services to people with mental health needs and drug/alcohol users, so it is essential that workers from these agencies and other specialist health services are included in training related to child safeguarding, and are aware of their responsibilities and appropriate responses under their local systems.**

1.13 References and Biography

DfES (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children.* London: The Stationary Office.

DfES (2007) *The Children's Plan. Building brighter futures* accessed at:
<http://www.dfes.gov.uk/publications/childrensplan>

Frank J and McLarnon J (2008) *Young Carers, Parents and their Families: Key Principles of Practice.* The Children's Society

Leadbitter, H (2007) *Whole Family Pathway – A whole family working resource for practitioners.* The Children's Society.

Social Exclusion Task Force (2008) *Think Family: Improving the Life Chances of Families at Risk.*

2. Part Two: Mental Health

The guidelines refer to people with mental health needs, from brief interventions to severe and enduring mental ill health. It is important that all workers should be aware that the term 'mental health need' covers a range of needs some requiring brief intervention in primary care, while others require referral to specialist mental health services.

2.1 Definition

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

2.2 Effect on parenting

2.2.1 All parents find parenting challenging at times, and those with a mental health need often show considerable inner strengths in adequately parenting their child. Being a parent with a mental health need however, may be particularly challenging. Many parents are painfully aware that their disorder affects their children even if they do not fully understand the complexities. (Royal College of Psychiatrist 2002, Falkov 1998).

2.2.2 All children even young children are sensitive to the environment around them. Thus their parents' state of mind can have an effect on even the youngest child. In this context, all children are vulnerable when a parent has a mental illness but children may be helped considerably where the parent is aware of this. (Stanley et al 2003).

2.2.3 The lack of capacity to parent well may not be the only reason for poor outcomes for children whose parents have mental illness. Factors such as the effects of poor housing, financial difficulties, domestic violence or hostile neighbourhoods may be a significant factor in parental stress and illness. (Stanley et al. (2003).

2.2.4 Strengths in the family, such as the ameliorating effects of another adult, can minimise the effects on children of the mental illness of a parent.

2.2.5 Questions about childcare and parenting issues are clearly sensitive and can have important implications for people with mental health needs. The stigma associated with mental illness may make parents reluctant to ask for help, as they fear their child or young person may be removed.

2.2.6 Families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas. It is government policy to promote the well being of children through timely and appropriate support. (Children Act 2004).

2.2.7 Assessment of the impact of these stresses on the child is an important factor in the care plan for the child and the care plan for the parent and reinforces the need to see mental health needs of parents/carers in the context of family life and functioning.

2.2.8 It is essential that an appropriate assessment of the parent/carer's needs is undertaken to assess the impact on any child involved with the family. Children have a right to have their own needs assessed, receive appropriate services and to be heard in their own right so that risk factors can be identified and minimised and protective factors promoted. In this way, children can be enabled to achieve their full potential.

2.3 Children's Services

- 2.3.1 When a referral is accepted by Children's Services an assessment will be undertaken. Where information gathered indicates the potential risk of significant harm to the child, child protection procedures must be initiated and the assessment conducted in accordance with these procedures.
- 2.3.2 Where Children's Services are already involved with a family where the parent or person with significant caring responsibility for children appears to have mental health needs, the practitioner should discuss with the parent whether they are receiving any support from either the Primary Health Care team (via their GP) or from Adult Mental Health Services, or any other service, and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.
- 2.3.3 If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted, by the Children's Services practitioner, in the first instance for his/her view of the family situation. Whether a referral for primary or secondary mental health services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing or midwifery services are being used, they should also be involved.
- 2.3.4 If the parent is receiving support from Adult Mental Health Services, the Children's Services practitioner should contact the person involved, and use their expertise and experience to help assess, or review, the parent's current and potential capacity to meet the child's needs, taking into account the support received from the mental health practitioner.
- 2.3.5 The referral pathway to Children's Services will vary between authorities; each agency should ensure that they are familiar with their local authority's process.
- 2.3.6 **NB This protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering or not likely to suffer significant harm. If the concerns are about neglect, or harm, whether emotional, physical or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay.** <https://www.dorsetlscb.co.uk> or www.bournemouth-poole-lscb.org.uk
- 2.3.7 When a referral is accepted by Children's Services, an assessment will be undertaken. The assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action needs to be taken by the Children's Services social worker to ensure the child's safety. In this case the mental health practitioner should be fully informed and be part of the child protection strategy planning.

2.4 Partnership Working

- 2.4.1 Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends upon effective communication and joint working.
- 2.4.2 Sharing information is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. (See *What to do if you're worried a child is being abused* 2006).
- 2.4.3 Joint working should be conducted within the boundaries of confidentiality, however

the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm. The duty of confidentiality to parents is not absolute and must not be allowed to stand in the way of a vulnerable child or adult. .

- 2.4.3 The National Service Framework (DoH 2004) recognises that many children have contact with a variety of professionals. If during an assessment, concerns arise that may require support from another agency, it is important for the professionals involved to work in partnership and to share relevant information as required in accordance with confidentiality obligations. (*Working Together to Safeguard Children* 2006 para 2.81).
- 2.4.5 Close collaboration and liaison between Adult Mental Health Services and Children's Services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. Systems should be in place to ensure that:-
- Managers working with adults can monitor those cases which involve dependent children.
 - There is regular, formal and recorded consideration of such cases with Children's (Social Care) staff.
 - If Adult and Children's Services are providing services to a family, staff communicate and agree interventions.

(Pan-Dorset Safeguarding Children Procedures 2007: <https://www.dorsetlscb.co.uk> or www.bournemouth-poole-lscb.org.uk)

- 2.4.6 In order to safeguard children of parents with whom they are working, mental health practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. (*Working Together to Safeguard Children* 2010 para 2.103-4).
- 2.4.7 Joint working should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm. The duty of confidentiality to parents is not absolute.
- 2.4.8 As part of the assessment process, mental health and primary care practitioners will offer professional assessments on the impact of the mental health need upon the parenting capacity of the person/s involved and childcare practitioners will offer professional assessments on the child. This information will assist in the construction of a plan that ensures the child's/children's safety, whilst also taking into consideration the needs of the parent/carer.
- 2.4.9 Practitioners will input into the decision making process of professional meetings and child protection conferences. Practitioners attend to offer professional assessments and not as advocates of the parent.
- 2.4.10 Should a practitioner feel that their role with the parent is being compromised, they should consider engaging the services of an advocate who can support and advise the parent and therefore free the practitioner to fulfil their responsibilities to the child protection conference.
- 2.4.11 It is not possible to give guidance to cover every circumstance in which sharing of information without consent will be justified. Practitioners must make a judgment on the facts of each case. Where there is clear risk of significant harm to the child, or serious

harm to the adult, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action; the information shared should be proportionate. (*What to do if you're worried a child is being abused* 2006. para 3.11).

2.5 Implications of Mental Health for parenting

- 2.5.1 The Royal College of Psychiatrists (2002) states that the links between mental illness and adverse outcomes for children is well established. For parents with mental health needs, difficulties, usually beyond their control, can create problems in parenting or in being the parents they would wish to be.
- 2.5.2 The failure of any parent to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development.
- 2.5.3 The Royal College of Psychiatrists (2002) states *the effect of parental psychiatric disorder on children's psychological welfare is determined by the social and relational consequences of the parent's disorder. It is the parental behaviour that creates the risk to the children. A parent who is self pre-occupied or emotionally and practically unavailable is more likely to neglect their children's health and well-being whereas a parent suffering from irritability or over-reaction to stress that accompanies anxiety, depression or psychosis may resort to over chastisement or physical abuse of the child'*
- 2.5.4 Where a child becomes incorporated into a parents paranoid or threatening delusions, this may pose a significant risk to the child. In their review of 35 child death cases, Reder and Duncan (1999) found that 43% of the parents were suffering from active mental health needs at the time the child died.
- 2.5.4 Parental personality factors (pre-existing and/or exacerbated by the illness) may mean parents have difficulty controlling their emotions, have an inability to cope or be self-preoccupied. Violent, irrational and withdrawn behaviour can frighten children
- 2.5.6. Poor compliance with treatment and problematic relationships with professionals are factors that influence parent's ability to be effective in the care of their children. (Royal College of Psychiatrist 2002).
- 2.5.7 Unmet mental health needs can lead to the child taking on responsibilities beyond their years because of their parent's incapacity. This may include becoming a carer for the parent and/or other children or family members.
- 2.5.8 The effects of parental mental ill health may be minimised and ameliorated by a caring adult who is available and cognisant of the fluctuating needs of the parents and can step in to provide a supportive stable environment for the child/young person.
- 2.5.9 Children may understand when things are not right and if their needs are not being met. They may not be able to, or want to say anything about it, or there may be no-one to tell; they may just get on with it by taking on inappropriate caring roles for their families.
- 2.5.10 The needs of the child in his own right should be assessed by the children's services social worker within a child plan which identifies the presence of another significant adult while the needs of the parent should be assessed and addressed by the mental health worker in order to support the parenting role (McDonald 2005 in Taylor and Daniel).
- 2.5.11 Fear of a child being removed from the parent is considered an obstacle to a parent seeking help for mental health needs.

2.6 Prenatal and Postnatal Period

- 2.6.1 Specific concerns apply to the pre- and post- natal periods. It is vital that there is joint working between the General Practice, Midwifery, Health Visiting and if involved, specialist Mental Health Services. It is essential to identify needs, assess and prepare safeguarding plans for both mother and child.
- 2.6.2 Post-natal depression (PND) is very common among new parents and may affect as many as one in six new mothers, typically in the first three months after delivery, sometimes lasting for six months or up to a year if left untreated. Maternal post-natal depression can be significantly harmful to young infants particularly between the ages of six to eighteen months of age with increased incidence of insecure attachment. The depression itself does not cause the damage it is the effect of the mother: child interaction and non-availability to the child that does the damage leading to emotional and cognitive difficulties, social withdrawal, negativity and distress. (Cox et al 1987, Murray et al 1996).
- 2.6.3 Women in the postpartum period have a greater risk of becoming psychotic. Puerperal psychosis affects two percent of the general population but affect 30 – 50% of woman with a previous significant history of mental illness. Relapse signature can predict onset and nature of illness.

2.7 Dual Diagnosis

- 2.7.1 Substance misusing parents may have mental health problems. It is important, therefore, to maintain effective links between the agencies involved. *Pathway to care for individuals with substance misuse and mental health needs are indicated in local guidance.*
- 2.7.2 Workers should consider the impact, especially with chronic severe mental illness with co-morbid disorders such a substance misuse or a personality disorder will have on parenting capability. Those with a dual diagnosis of mental health needs and learning disability may require extra support.

2.7 Services Contact Details (Mental Health)

Dorset HealthCare University NHS Foundation Trust HQ

11 Shelley Road
Boscombe
Bournemouth
BH1 4JQ

Tel: 01202 303400
Fax: 01202 701462

www.dorsethealthcare.nhs.uk

Dorset Community Health Services

Forston Clinic
Herrison
Dorchester
DT2 9TB

Tel: 01305 361300
Fax: 01305 361300

www.dorset-pct.nhs.uk/health_services/dorset_community_health_services/index.asp

2.9 References and Biography

- Browne K, Douglas J, Hamilton-Giachritsis C and Hegart J (2006). *A community Health Approach to the Assessment of Infants and their Parents: The Care Programme*. Chichester: John Wiley & Sons Ltd.
- Cassell, D. and Coleman, R (1995) Parents with psychiatric problems, in P. Reder and C Lucey (eds) *Assessment of Parenting: Assessment of Parenting: Psychiatric and Psychological Contributions*, London: Routledge, pp169-49.
- Commission for Social Care Inspection (2006) *Supporting parents, safeguarding children*, London: CSCI.
- Cox A.D, Puckering. C. Pound. A, AND Mills, M (1987) The impact of maternal depression in young children. *Child Psychology and Psychiatry*, vol 22, no 6, pp917-28.
- DfES (2004) *Every Child Matters. Change for Children*. London: The Stationary Office.
- DfES (2004) *National Service Framework for Children, Young People and Maternity Services*. London: The Stationery Office.
- DfES (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*. London: The Stationery Office.
- DoH and DfES (2004) *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health. Website:
www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en
- Falkov A (ed) (1998) *Crossing Bridges: Training recourses for working with mentally ill parents and their children*. Brighton: Pavilion Publishing
- Joyce L (2003) *Report of an Independent Inquiry into the Care and Treatment of Dasha Emson M.B.B.S, MRCPPsych, MSc and her Daughter Freya*. London: North East London NHS Strategic Health Authority.
- Leadbitter, H. (2007) *Whole Family Pathway – A whole family working resource for practitioners*. The Children's Society.
- Murray, L. Hipwell, A. and Hooper, R (1996) *Cognitive development of 5 year old children of postnatally depressed mothers*. *Child Psychology and Psychiatry*. Vol 37, no 8, pp927-35.
- Quinton and Rutter (1985) *Family psychology and child psychiatric disorder: a four year study*. In A>R> Nicol (ed) *Longtudinal Studies in child psychology and psychiatry*. Chichester. John Wiley, pp91-134.
- Reader P and Duncan S (1999) *Lost Innocents a Follow-up Study of Fatal Child Abuse*. London and New York Routledge.
- Royal College of Psychiatrist (2002) *Patients as Parents: Addressing the needs, including the safety of children whose parents have mental illness*. London: Royal College of Psychiatrist CR 105.
- Royal College of Psychiatrist (2004) *Child Abuse and Neglect: The role of Mental Health Services*. London: Royal College of Psychiatrist CR 120.
- Stanley N, Penhale B, Riorden D, Barbour RS and Holden S (2003) *Child Protection and Mental Health Services: Inter-professional responses to the needs of mothers*. Bristol: The Policy Press.

3. Part Three: Drugs and Alcohol

Parental misuse of drugs or alcohol becomes relevant to child protection when the misuse of the substances impacts on the care provided to their child/ren.

Foreword

'all drug-misusing parents with treatment needs to have ready access to treatment, with all problem drug user parents whose children are at risk having prompt access to treatment, with assessments taking account of family needs'.

Drugs: protecting families and communities
(Home Office, 2008)

By taking a whole family approach and by working closely together, drug and alcohol services, dedicated young carer services and children, parenting and family services can meet the needs of parents whose substance misuse is adversely affecting the whole family.

These guidelines have been written for use by all services working with drug or alcohol misusers who are parents or carers of children. There are many voluntary and statutory agencies providing services for drug and alcohol users and their families. All these agencies must recognise the importance of working together, particularly in assessing the needs of children of parents/carers who use substances.

Further sub-protocols may need to be developed within the respective Dorset, Poole and Bournemouth areas and possibly between services within these areas as required to underpin the implementation.

Pan Dorset overarching protocol (this document)		
Dorset <i>Sub-protocol(s)</i> <i>as required</i>	Poole <i>Sub-protocol(s)</i> <i>as required</i>	Bournemouth <i>Sub-protocol(s)</i> <i>as required</i>

In implementing this protocol, services will need to consider whether their local protocol will impact differentially on the groups and communities that are being supported and take steps to address any issues identified. This should include an evaluation using the Local Authority or NHS Equality Impact Assessment process to further inform the protocol development.

3.1 Definitions

3.1.1 Substances

'Substance' is used to refer to any psychotropic substance (capable of affecting the mind – changing the way we feel, think and or behave) including alcohol, tobacco, drugs sold as 'legal highs', illegal drugs, illicit use of prescription drugs and volatile substances such as solvents (gases, lighter and other fuel) some plants and fungi (magic mushrooms); over-the-counter and prescribed medicines that are used for recreational rather than medical purposes.

3.1.2 Substance Use

Substance use is drug taking which requires a lower level of intervention than treatment. Harm may still occur through substance use, whether through intoxication, illegality or health problems, even though it may not be immediately apparent. Substance use requires the appropriate provision of interventions such as education and advice, targeted prevention and brief interventions to reduce the potential for harm.

3.1.3 Substance Misuse

Substance misuse is where substance taking harms health or social functioning. It may cause dependency (physical or psychological). Drug taking in this context may also be part of a wider spectrum of problematic behaviour. Substance misuse will require treatment.

3.1.4 Substance use/misuse by parents/carers does not, on its own, automatically mean that children are at risk of abuse or neglect, but workers must recognize that children of substance misusers are a high-risk group. Furthermore, adults who misuse substances may be faced with multiple problems, including homelessness, accommodation or financial difficulties, difficult or damaging relationships, lack of effective social and support systems, issues relating to criminal activities and poor physical/and or mental health. Parents or carers who experience domestic abuse may use or misuse substances as a coping mechanism. Substance misuse may cause or exacerbate abuse within a relationship. Assessment of the impact of these stresses on the child is as important as the direct impact of substance misuse. It reinforces the need to see substance misuse by parents/carers in the context of family life and functioning, and not purely as an indicator or predictor of child abuse and neglect.

3.1.5 Questions about childcare and parenting issues are clearly sensitive and can have important implications for substance misusing parents. The need to gain information must be balanced against deterring substance users from accessing appropriate treatment. Whilst parents have the right to confidentiality in most circumstances, society has a duty to protect children who cannot advocate for themselves. While a professional's primary relationship may be with the parent, where there is cause for concern, information must be shared on a 'need to know' basis with the appropriate children's services. This should be conducted within the boundaries of confidentiality. The emphasis should be on working collaboratively with parents and other professionals to optimize the care of children and protect them from harm or risk of harm.

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

3.2 Effects on Parenting (drugs)

- 3.2.1 In some cases drug misuse can become a higher priority for the parent than buying basic essentials for the family.
- 3.2.2 Parent's behaviour may result in basic standards of hygiene being neglected.
- 3.2.3 Drug misuse may result in some parents having difficulty organising their lives. This may result in inconsistent and ineffective parenting.
- 3.2.4 Drug misuse may mean parents have difficulty controlling their emotions. Violent, irrational and withdrawn behaviour can frighten children.
- 3.2.5 The extreme nature of their parents' drug misuse may cause the child's life to revolve around it, and lead to the child taking on responsibilities beyond their years because of their parent's incapacity.
- 3.2.6 Drug misuse may result in the parent placing their own needs before those of their children, and lead them to being cared for by a large number of other people. There may also be reduced vigilance by the parent leaving children vulnerable to abuse by visitors to the home.
- 3.2.7 Parenting is most likely to be negatively affected where drug misuse is uncontrolled or chaotic, and the parent/carer swings between states of severe intoxication and withdrawal, particularly when substances are mixed.
- 3.2.8 Drug misuse may result in a parent/carer becoming unconscious or incapable while looking after the child, or failing to notice or get treatment for a child when s/he is ill or has had an accident.
- 3.2.9 Drug misuse may lead to violence toward a child, or domestic violence towards a partner, accompanied by its adverse impact on the child's emotional well-being.
- 3.2.10 Drug misuse may lead to the parent becoming intensely worried about obtaining their next fix, with the result that the child is left alone, or, alternatively, taken to places which are unsuitable or unsafe.
- 3.2.11 The drug-misusing parent may be driven to committing crimes or resorting to prostitution to finance their habit, with the result that the child is left alone, or alternatively taken to places which are unsuitable or unsafe, or ultimately separation from their child by a prison sentence.
- 3.2.12 Parental drug misuse may lead to the disruption of relationships with the extended family, and as a result, make it less available to the child as a protective factor.
- 3.2.13 Drug misuse may lead to parents being careless about the safe storage of their methadone/other drugs, needles and syringes.

3.3 Effect on Parenting (alcohol)

- 3.3.1 Parental alcohol use may lead parents to neglect their own needs and those of their children.
- 3.3.2 Drinking may lead parents to lack awareness of their surroundings and even loss of consciousness, increasing the risk to children's health and safety.

- 3.3.3 Problem drinking can result in a parent being emotionally unavailable, inconsistent and unpredictable: swinging from 'caring, loving and entertaining to violent, argumentative, and withdrawn'. This may cause parents to behave in a way that frightens their children.
- 3.3.4 Children's attachments to their parents may be disrupted as parent's problem drinking can lead to them to be impassive, angry and critical of their children. Also, if a parent's attachment is primarily to alcohol this can result in children feeling loss and abandonment.
- 3.3.5 Parental alcohol misuse can make it harder for parents to manage their lives, which can lead to inconsistent and ineffective parenting.

3.4 Expectations on practice for Adult Treatment Services

- 3.4.1 Adult treatment services will routinely screen clients for childcare responsibilities at the triage/comprehensive assessment stage and as an ongoing process throughout their treatment journey and monitored by service managers via supervision.
- 3.4.2 Where a drug/alcohol using client has responsibility for the care of child(ren), the appropriate risk assessment should have been undertaken and indicated the level of intervention required. Local guidance on the use of the Common Assessment Framework (Pre-CAF and CAF) should be followed which may result in a referral to Children's Services. Should the level of risk/harm not meet the threshold for referral to children's social care services it may nevertheless be required to develop some level of intervention. Resulting actions identified must be recorded within the Risk Assessment Plan. A locally recognised *Capacity to Parent* tool may helpful when making decisions.

3.5 Expectations on practice for Children's Services

- 3.5.1 When a referral is accepted by Children's Services an assessment will be undertaken. Where information gathered indicates the potential risk of significant harm to the child, child protection procedures must be initiated and the assessment conducted in accordance with these procedures.
- 3.5.2 Where Children's Services are involved with a family where the parent or person with significant caring responsibility for children appears to be using drugs or alcohol in a way which may affect their parenting, the practitioner should discuss with the parent whether they are receiving any support from any other service relating to their drugs/alcohol use, and whether they will consent to have information shared with other practitioners. The benefits to the family of sharing information should be explained.
- 3.5.3 If there are concerns relating to the parent's needs, and no other services are involved, the parent's GP should be contacted, by the Children's services practitioner, in the first instance for his/her view of the family situation. Whether a referral for primary or secondary substance misuse services is required should be discussed. This is particularly important where there is an unborn or very young child. Where nursing or midwifery services are being used, they should also be involved.
- 3.5.4 If the parent is receiving support from substance misuse services, the Children's Services practitioner should contact the person involved, and use their expertise and experience to help assess, or review, the parent's current and potential capacity to meet the child's needs, taking into account the support received from the mental health practitioner.

- 3.5.5 The referral pathway to Children's Services will vary between authorities, each agency should ensure that they are familiar with their local authority's process.
- 3.5.6 **NB This protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering harm. If the concerns are about neglect, or harm, whether emotional, physical or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay.**
- 3.5.7 When a referral is accepted by Children's Services and an assessment undertaken, the assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action needs to be taken by the Children's Services social worker to ensure the child's safety. In this case the substance misuse practitioner should be fully informed and be part of the child protection strategy planning.

3.6 Expectations on practice for partnership working

- 3.6.1 **Effective joint working** is essential to safeguarding and promoting the welfare of children, and in particular protecting them from significant harm.
- 3.6.2 **Sharing information** is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. (See *What to do if you're worried a child is being abused* 2006)
- 3.6.3 **Joint working** should be conducted within the boundaries of confidentiality, however the emphasis should be on working collaboratively with parents and other professionals to maximize the care of children and protect them from harm or risk from harm. The duty of confidentiality to parents is not absolute.
- 3.6.4 The National Service Framework (DoH 2004) recognises that many children have contact with a variety of professionals. If during an assessment, concerns arise that may require support from another agency, it is important for the professionals involved to work in partnership and to share relevant information as required in accordance with confidentiality obligations. (*Working Together to Safeguard Children* 2006. para 2.81).
- 3.6.5 **Close collaboration and liaison** between drugs and alcohol services and children's services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. Systems should be in place to ensure that
- Managers working with adults can monitor those cases which involve dependent children.
 - There is regular, formal and recorded consideration of such cases with Children's Services (Social Care) staff.
 - If Adult and Children's Services are providing services to a family, staff communicate and agree interventions.
- 3.6.6 To safeguard children of parents with whom they are working, drug and alcohol practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. (*Working Together to Safeguard Children* 2006 paras 2.93-4)
- 3.6.7 As part of the assessment process, drug and alcohol practitioners will offer professional assessments on the impact of the substance misuse problem upon the parenting

capacity of the person/s involved and childcare practitioners will offer professional assessments on the child. This information will assist in the construction of a plan that ensures the child/ren's safety, whilst also taking into consideration the needs of the parent/carer.

3.6.8 Substance misuse practitioners will input into the decision making process of professional meetings and child protection conferences. Practitioners attend to offer professional assessments and not as advocates of the parent.

3.6.9 It is not possible to give guidance to cover every circumstance in which sharing of information without consent will be justified. Practitioners must make a judgment on the facts of each case. Where there is clear risk of significant harm to the child, or serious harm to the adult, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action; the information shared should be proportionate. (*What to do if you're worried a child is being abused* 2006.para 3.11)

3.6.10 **See Appendix 3 for an example of a Joint Working Protocol Pathway**

3.7 Implications of parental drug misuse

3.7.1 Any failure of drug misusing parents to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development, resulting in a failure to thrive.

3.7.2 The worker must also be aware of the possibility that the parents may be feeding the child substances on a regular basis.

3.7.3 **See Appendices 4a – 4b for the Summary of Potential Impact of Parental Drug use on Developmental Stages and Appendix 6a - 6b Summary of Protective Factors in relation to Parental Substance Misuse**

3.8 Implications of parental alcohol misuse

3.8.1 Alcohol misuse may have significant adverse effects on parenting including inconsistency, emotional detachment and neglect. Family life can become characterized by chaos and lack of routine, and in some cases unpredictable behaviour associated with mental health needs and violence. Many parents struggle to meet their children's basic care needs or provide adequate emotional support, and children may have to rely on their own coping strategies or resilience or the support of others to get by.

3.8.2 **See Appendices 5 for Summary of Potential Impact of Parental Alcohol use on Development Stages and Appendix 6a- 6b Summary of Protective Factors in relation to Parental Substance Misuse**

3.9 Pregnant women who misuse drugs and alcohol

- 3.9.1 This protocol is intended to reflect a clear and consistent policy for those working with pregnant women and their partners who use substances, with a view to encouraging their co-operation with the relevant agencies. The overall objective is to ensure the physical well being of both the mother and child, and enable the baby to be safely discharged from the hospital to the care of the mother/partner wherever possible. The pre – discharge meeting should include an assessment of the partner and consideration should be given to the resources needed to support the family following hospital discharge.
- 3.9.2 The pregnant women, and or her partner who are substance user/misusers are likely to feel guilty about the harm they may be causing to the baby, and fearful of the judgment of others. As soon as any agency comes into contact with a pregnant woman or a partner who is misusing substances, they should offer reassurance that all agencies will work with the family to enable them to care for the baby, and that the baby will not automatically be removed or become the subject of a Child Protection Conference because of substance misuse. Where available, a written guide to the policy should be provided and explained to women and their partners. It is important that policies and expectations should be as explicit as possible.
- 3.9.3 The woman’s consent is not required in order to share information within a single agency, i.e. health professionals need to be able to liaise with each other in order to deliver a client needs led service. The same applies to children services teams. Where teams are integrated across agencies this will aid timely and effective information sharing across professional groups.
- 3.9.4 Ongoing use of substances through pregnancy is particularly damaging in the second trimester of pregnancy (14 - 26 weeks), especially if using ‘street drugs’ which maybe impure and mixed with various substances.
- 3.9.5 Failure to address the issues early in pregnancy will not encourage attendance at antenatal appointments, engagement with substance misusing services, or modification of lifestyle.
- 3.9.6 Clear plans will be made from agency meetings in respect of the expectations of the parents to engage with and attend appropriate services.
- 3.9.7 Planning will enable early involvement and monitoring and should prevent a reactive service occurring late in pregnancy.

3.10 Dual Diagnosis

- 3.10.1 Many substance misusing parents suffer from mental health needs. It is important, therefore, to maintain effective links between the agencies involved. (*Pathway to care for individuals with substance misuse and mental health needs are indicated in local guidance.*)

3.11 Substance Misusing Offenders

- 3.11.1 In August 2007, the Home office Drug Interventions Programme (DIP) published “*Around Arrest, Beyond Release*” which explored the experiences and needs of families (including children) of drug misusing offenders, particularly at arrest and on release. Some of the suggestions for future practice which practitioners might wish to explore and may help further safeguard these children include:

- Establishing prior to a planned raid on a domestic property whether children are likely to be present and if so ensuring attendance of a child or family welfare professional when possible. Children should also be able to have supervised access to a familiar carer during searches on domestic properties.
- Following their arrest, there should be prompt identification of those arrestees who have caring responsibilities for children so that alternative care arrangements can be made.
- Assessment of family circumstances, including any immediate needs for children, both at arrest and prior to release of drug misusing offenders.
- The need for all family members (including children and young people) to receive support in their own right.

3.12 Service Contact Details (Drugs and alcohol)

Please use the following links to find the latest information on service contact details

Dorset

Tel: 01305 224100

<http://www.dorsetforyou.com/drugsandalcohol>

Poole

Tel: 01202 633635

http://www.poole.gov.uk/adult_social_services_commissioning/services/ref:S46487D4332C83/aka:Drug+Action+Team/

Bournemouth

Tel: 01202 458705

<http://www.bournemouth.gov.uk/daat/>

4. Part Four: Appendices

Appendix 1 - Practice Guidelines

The Royal College of Psychiatrist (2002) suggest the following practice guidelines:

Some factors that need to be considered in assessing if there is a risk to children where a parent has mental health needs are:

- the impact of the illness on the adult (being a parent and having a mental illness), especially chronic severe illness with co-morbid disorders, such as episodes of mental illness complicated by substance misuse or the presence of a personality disorder.
- poor compliance with treatment, problematic relationships with professionals and diagnostic uncertainty.
- parental personality factors (pre-existing and/or exacerbated by the illness, e.g. irritability, hostility, inability to cope, self-preoccupation, etc).
- a history of overdose and self-harm (prior to and especially since having children), especially when there has been more than one such action.
- a parent's own experience of severe childhood trauma and adversity, including discontinuities in carers and experience of abuse and being 'looked after' (in care).
- a history of violence (as a perpetrator or a victim) with unstable, discordant parental relationships.
- environmental stressors outweighing support and protective factors – for example, poor quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status and mental illness), material deprivation and poverty.
- parents with a learning disability.

Children who adapt well to a parent's mental illness will typically exhibit at least some of the following:

- older age at the time of the onset of their parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources).
- being more sociable and able to form positive relationships (having an easier temperament).
- greater intelligence.
- a parent who has discrete episodes of mental illness with a good return of skills and abilities between episodes.
- alternative support from adults with whom the child has a positive, trusting relationship
- success outside of the home (e.g. at school, in sport).

Royal College of Psychiatrists (2002) *Patients as Parents: Addressing the needs, including the safety of children whose parents have mental illness*. London: Royal College of Psychiatrist CR 105.

Appendix 2

Summary of Potential Impact on a Child of primary and secondary behaviours associated with parental psychiatric disorder

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

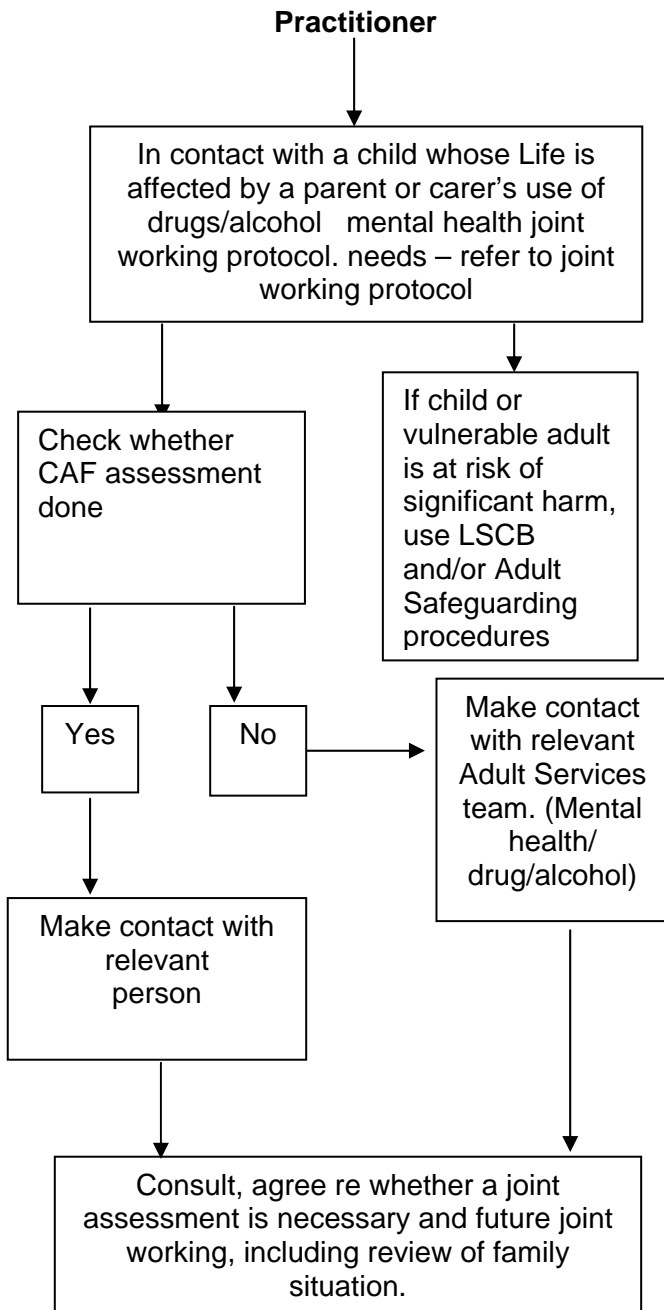
Source: Reder, P., McClure, M. & Jolley, A. (2000) *Family Interfaces Between Child Matters and Adult Mental Health*

Appendix 3

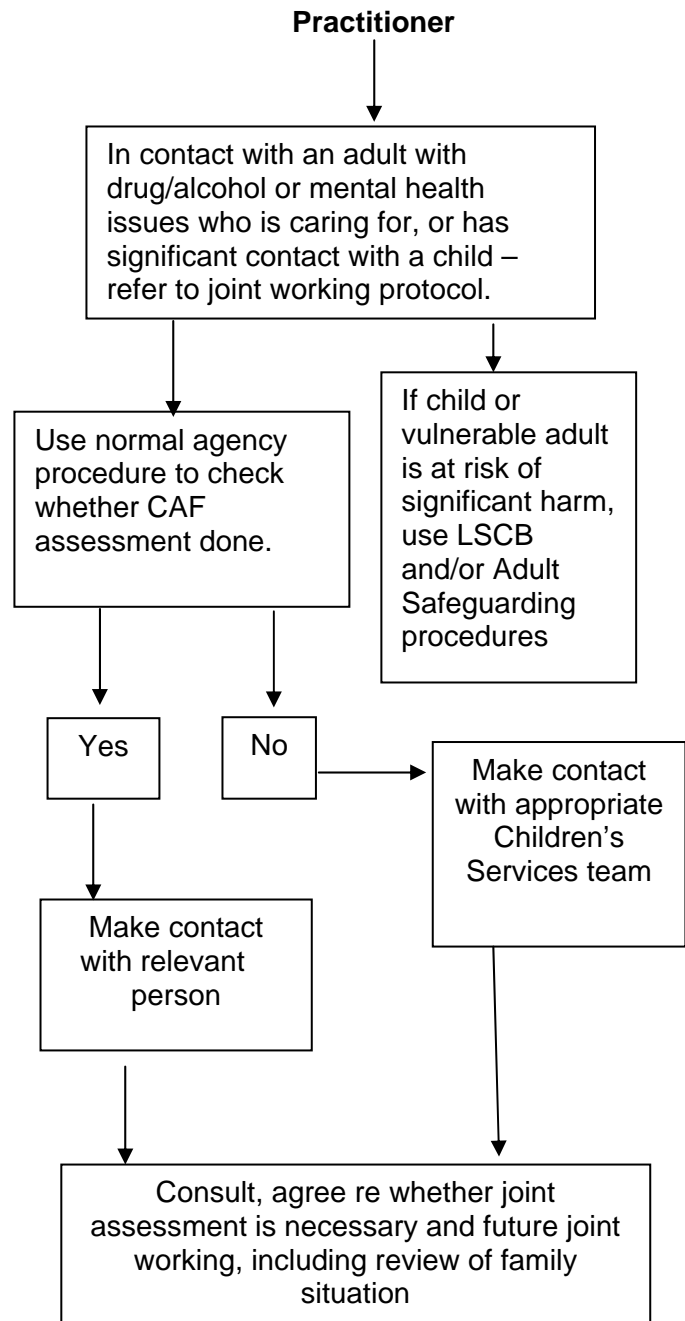
JOINT WORKING PROTOCOL

Safeguarding children whose parents/carers use drugs/alcohol

Children's Services



Mental Health & Substance Misuse Services



Appendix 4a Summary of Potential Impact of Parental Drug Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 2	Substance misuse during pregnancy may result in symptoms of withdrawal	Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglectful behaviour.	Care of children by different strangers at different times can lead to insecure attachments and safeguarding concerns.	A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses and emotional insecurity in the child.
3 – 4	Children may be placed in physical danger by excessive parental drug misuse, <i>and by the presence of drugs in the home</i> . Children's physical needs may be neglected.	Lack of stimulation. Nursery or pre-school attendance may be irregular.	Children may take on responsibilities beyond their years because of parental incapacity.	Children may be at risk because they are unable to tell anyone of their distress.
5 – 9	School medicals and dental appointments missed. Psychosomatic symptoms e.g. sleep problems, bedwetting	Academic attainments may be negatively affected and children's behaviour in school may become problematic.	Children may develop poor self-esteem, and may blame themselves for their parents' problems. Because they feel shame and embarrassment over their parents' behaviour, children may curtail friendships and social interactions.	Conduct disorders with boys e.g. hyperactivity, inattention. Depression and anxiety in girls Children may be in denial of their own needs and feelings

Appendix 4b Summary of Potential Impact of Parental Drug Misuse - continued

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
10 – 14	<p>Little or no support during puberty because of parental emotional withdrawal.</p> <p>Early experimentation with substances more likely.</p>	<p>Continued poor academic performance due to caring for siblings or parents.</p> <p>Higher risk of school Exclusion.</p>	<p>Restricted friendships.</p> <p>Poor self image and low self esteem.</p>	<p>Children are at increased risk of emotional disturbance and conduct disorders, including bullying.</p> <p>They are also at risk of becoming drug misusers themselves.</p>
15 +	<p>Increased risk of problem substance misuse.</p> <p>Risk of pregnancy, STIs and failed relationships.</p>	<p>Poor life chances due to poor school attainment or exclusion because of behavioural problems.</p>	<p>Lack of appropriate role Models.</p>	<p>Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to crime.</p>

Appendix 5a Summary of Potential Impact of Parental Alcohol Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 2	Health risks to children include direct physical harm, including risk of serious injury or death by overlaying parents failing to ensure that the environment is safe and harm caused by impaired physical concentration, can lead to problems completing breastfeeding or nappy changing.	Possible delay in cognitive development due to lack of appropriate and consistent stimulation.	Attachments to parents may be problematic or insecure because of inconsistent and chaotic behaviour and emotional withdrawal. Children can feel loss and abandonment if drinking behaviour is placed above child's needs.	Infants may have unsuitable clothing and poor hygiene. Indifference and despair that can accompany problem drinking can mean parents do not respond to or reassure their child in appropriate and positive manner – may lead to child to believe they are unloved and unlovable.
3 – 4	When a parent is intoxicated the ability to care for children can decline, and children can be at risk from both direct physical harm and neglect. Children may be left home alone or with unsuitable carers if parents place their drinking behaviour above child's needs.	Child may have cognitive deficit due to insufficient emotional stimulation and interaction. Nursery or preschool attendance may be irregular since problem drinking often results in parents being disorganised or inactive.	Children commonly blame themselves for family's problems and attempt to put things right in vain attempt to make their environment better able to support them.	Children may be more at risk of emotional disturbance as they cannot easily articulate emotions. The level of this disturbance may be missed as child's behaviour does not always reflect their mental state.

Appendix 5b Summary of Potential Impact of Parental Alcohol Misuse - *continued*

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
5 – 9	Children may experience head and stomach aches, allergies, sleeping problems and bed-wetting	<p>Academic performance may be negatively affected with school attendance, punctuality, preparation and concentration also potentially affected.</p> <p>In contrast, some children may immerse themselves in their studies and attain well.</p>	Children may suffer from low self-esteem and feel that they are not in control of events in their life. They may find it harder to see themselves as an individual separate to the family problems.	<p>Girls may internalise the depression, fear, anxiety and stress caused by their parent's inconsistent and chaotic behaviour, by withdrawing into make-believe.</p> <p>Boys may externalise the distress, resulting in conduct problems, hyperactivity and lack of concentration</p>
10 – 14	<p>Children may receive no support through puberty because of parental emotional withdrawal.</p> <p>They may have difficulty in developing healthy and balanced attitudes to alcohol as a result of parental alcohol use – experimentation with alcohol and other drugs may be more likely</p>	Academic performance may be negatively affected due to children's concern about parental problem drinking, which can lead to children staying at home to care for family.	<p>If parents' lives revolve around drinking, children may develop low self-esteem and blame themselves for the drinking.</p> <p>If income is directed primarily at parents' drinking, children may find it hard to maintain an acceptable appearance, causing them to be highly self-conscious, and may lose friendships as a result.</p>	<p>Children may externalize the distress caused by parental drinking problems, resulting in conduct problems.</p> <p>These ways of externalizing/internalising difficult feelings can lead to children being labelled or identified as 'the problem' by their families and others.</p>

Appendix 5c Summary of Potential Impact of Parental Alcohol Misuse - *continued*

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
15 +	<p>Can lead to teenagers to drinking extremes, either mirroring their parents' problem drinking or abstaining.</p> <p>Risk of pregnancy, STIs and failed relationships are higher if parents, who may be emotionally withdrawn, do not discuss these issues with teenagers.</p>	<p>Caring responsibilities can impact negatively on a teenager's education, and their future employability.</p> <p>If excluded from school, parents may be incapable of getting children back into school or supporting their continued learning.</p>	<p>If parents' behaviour is inconsistent and chaotic, children may have low self esteem, feel rejected, isolated, unable to control events in their life.</p>	<p>Teenagers may show extremes of behaviour that are beyond parental control.</p> <p>Adolescents may resort to stealing when income is spent on parental drinking, and this criminal and antisocial behaviour may bring them into contact with the Criminal Justice System.</p>

Appendix 6a Summary of Protective Factors in relation to Parental Substance Misuse

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
0 – 5	<p>Good regular ante-natal care Support for the expectant mother of at least one caring adult.</p> <p>Medicines and illicit drugs are safely stored.</p> <p>Sufficient income and good physical living standards.</p>	<p>Regular supportive help from primary health care team and Children & Families.</p>	<p>The presence of a caring adult who responds appropriately to the child's needs.</p>	<p>The presence of a caring adult who responds appropriately to the child's needs.</p>
6 – 9	<p>Attendance at school Medicals.</p>	<p>Regular attendance at school. Sympathetic, empathetic and vigilant teachers.</p>	<p>A supportive older sibling. Children who have at least one mutual friend have higher self-worth and are less lonely than those without. Social networks outside the family, especially with a sympathetic adult of the same sex.</p> <p>Belonging to organised out of school activities</p> <p>Being taught different ways of coping and knowing what to do when parents are Incapacitated.</p>	<p>The presence of an alternative, consistent, caring adult who responds appropriately to the child's cognitive and emotional needs.</p>

**Appendix 6b Summary of Protective Factors in relation to Parental Substance Misuse -
*continued***

Age (years)	Health	Education and Cognitive Ability	Relationships and Identity	Emotional and Behavioural Development
10 – 15 +	Factual information about puberty, sex and contraception.	<p>Regular school attendance.</p> <p>Sympathetic, empathetic and vigilant teachers. A champion who acts vigorously on behalf of the child.</p> <p>For those longer in school, a job.</p>	<p>A mentor or trusted adult to whom the child can discuss sensitive issues.</p> <p>Practical and domestic help.</p>	<p>A mutual friend.</p> <p>Unstigmatised support of relevant professionals.</p> <p>The ability to separate themselves either psychologically or physically from stressful family situations.</p>

Appendix 7 GLOSSARY DESCRIPTIONS AND CATEGORIES OF COMMON MENTAL DISORDERS

It should be noted that categories and descriptions of mental disorders vary across time and within different cultures. The important point is how the symptoms impinge on the life of the individual as a parent in terms of their parenting capacity and the impact the symptoms have on their children.

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DEFINITIONS

Schizophrenia

Schizophrenia affects one person in a 100. It is a debilitating and enduring disorder but can often be effectively controlled with medication. The individual may describe:

- Distorted thinking and perception which can lead to behaviour that is chaotic or out of character;
- intimate thoughts, feelings and acts are felt to be shared by others.
- hallucinations: Seeing, hearing, feeling or smelling something that doesn't exist;
- delusions which are false beliefs: for example believing they are famous, someone is controlling their thoughts, they have special powers, they are being followed by secret agents;
- thought disorder where thoughts don't link up correctly and the speech as a consequence is muddled and often difficult to comprehend;
- loss of feelings or emotions so the individual presents in a flat detached way;
- loss of energy and interest so the individual presents as unmotivated or lazy.

Bipolar affective disorder

Bipolar disorder is characterized by significant mood swings lasting usually weeks or months. Often a period of mania is followed by depression prior to the mood state normalising. It is an enduring disorder but can be controlled by medication. During manic episodes, a person will:

- Sleep very little;
- have all sorts of new ideas and plans;
- their activity level will dramatically increase;
- they may lose touch with reality and experience grandiose false beliefs and even hallucinations;
- they may become disinhibited putting themselves at risk;
- they may spend excessively or give away money resulting in large debts;
- they may overindulge in alcohol, smoke excessively and use illicit substances;
- they frequently come to the attention of the police creating a public disturbance or driving too fast.

During a depressive phase a person will experience many of the following:

- Low mood which may fluctuate;
- a sense of hopelessness and despair which can lead to thoughts and plans of suicide;
- loss of energy and concentration;
- a desire to withdraw from people leading to isolation;
- a lack of motivation which may impede everyday activities such as eating, sleeping and generally looking after themselves and their families;
- feelings of low self esteem and vulnerability.

Schizoaffective Disorder

An individual is diagnosed with schizoaffective disorder when schizophrenic symptoms present in combination with marked mood swings. It is not always easy to differentiate between schizophrenia, bipolar affective disorder and schizoaffective disorder. Treatment of schizoaffective disorder usually consists of antipsychotic and mood stabilizing medication.

Unipolar Depression (commonly known as 'clinical depression')

Unipolar depression although sharing similarities to bipolar depression is a separate disorder that can be effectively treated with a combination of antidepressant medication and psychological interventions.

Typically an individual will present with:

- Sleep disturbance and early morning waking;
- low mood often associated with anxiety and frequently worse in the mornings.
- Loss of appetite with marked weight loss; occasionally the opposite is seen with comfort eating and weight gain;
- poor concentration;
- repetitive depressive thoughts or worries;
- low self esteem;
- inappropriate feelings of guilt and self blame.

As the depression deepens individuals become increasingly withdrawn and hopeless.

Their thinking becomes delusional. They may experience suicidal ideation and start to make plans to kill themselves.

The Postnatal Period up to 1 year

At least 10% of all women following the birth of their baby will become mentally ill during the first year. Illnesses range in severity from puerperal psychosis to all degrees of postnatal depression.

Depression in the Postnatal Period

Can be mild, moderate or severe with or without biological symptoms and can be combined with prominent symptoms of anxiety, panic and obsessional phenomena. At the most severe end it can merge with puerperal psychosis:

- The majority of cases present 8- 12 weeks after delivery: the most severe cases tend to present earlier at 4-6 weeks;
- Severe depressive illness with biological features affects at least 3% of all delivered women;
- Women with a previous history of severe postnatal depressive illness or severe depression at other times or a family history of the condition are at increased risk of relapse;
- Post natal and other depressive illnesses adversely affect family structure and functioning leading to unwanted divorce or separation. (Cox 1999 – Weir & Douglas 'Child Protection & Adult Mental Health' (1999) Butterworth Heinemann.)

Puerperal Psychosis

The most severe form of postpartum disorder:

- Leads to 2 per 1000 women being admitted to a psychiatric hospital following childbirth, mostly in the first few weeks
- Most women will have been previously well
- Risk factors emerging consistently from the literature are a past psychiatric history, poor social support, a first baby and to a lesser extent a previous stillbirth
- Its onset is early and acute, frequently presenting in the first 14 days post delivery. Rarely within 48 hours of delivery most commonly suddenly between days 3 and 7
- The earliest signs tend to be perplexity, fear or terror and restless agitation associated with insomnia. Other signs include purposeless activity, uncharacteristic behaviour, disinhibition, irritation, fleeting anger and resistive behaviour
- Presentation is variable throughout the day with elation, grandiosity, suspiciousness, paranoia, depression and unspeakable ideas of horror
- Concentration is grossly impaired and the mother's ability to care for her own basic needs and those of her baby are usually grossly impaired

Anxiety

Pathological anxiety is constant and unrealistic worry about daily life. It can affect the person's ability to concentrate, leading to restlessness and disturbed sleep patterns. It may also give rise to physical symptoms such as rapid heartbeat, digestive upsets, tensions in muscles giving rise to aches and pains. Psychological interventions are first line treatment for this disorder.

Phobias

A phobia is an unreasonable fear of a situation or object. It can cause disruption to a person's life if it imposes restrictions on the way they live. For example agoraphobia, a fear of going out into open spaces can result in a person becoming isolated in their own home unable to work, shop or socialize. Alternatively claustrophobia, a fear of enclosed spaces can affect activities such as shopping, or going to the cinema or anywhere that is crowded. Other phobias include fear of animals, heights or flying.

Obsessive-compulsive disorder

Obsessive-compulsive disorder (OCD) is characterized by the presence of obsessions or compulsions, but commonly both.

- Often the people affected have tended to be perfectionists but it can be triggered by major life events or start during a period of depression
- Frequently the disorder starts at an early age, 92% develop OCD before the age of 40 years some in childhood
- On average it takes people 12 years to ask for help
- 11% of all people have OC symptoms and about 2 % develop OCD sometime in their lives

OCD causes marked distress, consumes time and interferes with ones daily routine, ability to work, relationships and family life.

Eating disorders

Eating disorders are characterized by an extreme preoccupation with food or calories and bodyweight and shape. The person with an eating disorder often has a distorted body image, believing they are overweight when they are extremely underweight. They may also have rituals around food and its preparation and have difficulty eating in the company of others.

There are two main types of eating disorder; anorexia nervosa and bulimia nervosa.

Anorexia nervosa

In anorexia nervosa the person restricts their eating and loses weight. The restriction is often accompanied by a sense of triumph over being in control and able to manage without food. In reality the control quickly gives way to an overriding fear of food. Restriction of food intake gives rise to physical symptoms, for example cold extremities and weakness. In women periods cease and, in extreme cases, the starvation can be life threatening. People with anorexia may also exercise compulsively as a means of controlling shape and weight.

Bulimia Nervosa

In bulimia nervosa, while still preoccupied by food and body weight and shape, the person has episodes of overeating when they will feel out of control. These are referred to as binges; in extreme cases the sufferer may eat anything and everything they can get their hands on. A binge may be followed by vomiting, taking laxatives or occasionally diuretics as a means of getting rid of the calories. As in anorexia, they may also exercise compulsively. Binges can alternate with periods of restricting food intake. Often there is denial of symptoms and body weight may be in the normal range.

The aetiology is complex for both disorders. In some individuals it will relate to poor or frankly abusive parenting of the individual. In others there may have been a past history of unsuccessful dieting for weight problems. Psychological therapies are the mainstay of treatment for mild to moderate disorders. At the more severe end of the spectrum admission to specialised units with structured re-feeding is required.

Asperger's Syndrome

This condition occurs predominantly in men of normal intelligence. It is a developmental disorder. There is poor appreciation of socio-emotional cues leading to odd social behaviours that can be construed as cold or rude.

Routines tend to be ritualistic, for instance meals tend to be of certain foods which have to be set out on the plate in specific patterns. Interests are frequently novel and pursued for a prolonged period in an obsessional way, for instance collecting rucksacks and solving mathematical puzzles.

Personality Disorder: Emotionally Unstable

- Typically the individual has had a deprived and abusive childhood
- Personality disorders are diagnosed from late adolescence
- Mood is dysregulated sometimes swinging violently from hour to hour
- Behaviour is impulsive and may be risky
- When prevented from behaving impulsively in ways that puts them or others at risk, often they respond by becoming violent and aggressive
- There is a tendency to become involved in unstable relationships which lead to emotional crises
- There is a tendency towards repeated episodes of self harm by overdoses or cutting, sometimes leading to suicide
- Frequently behaviours are exacerbated by the use of alcohol and illicit substances

Substance Misuse

This is a term which refers to the harmful use of any substance, such as alcohol, a street drug, a prescribed drug or over the counter medication resulting in any or all of the following:

- Excessive use;
- Repeated use;
- A harmful effect on the persons life;
- inability to fulfil life responsibilities

Increased usage results in

Substance Dependence which is characterised by:

- Craving
- Loss of control of use of the substance
- Physical dependence with the need to keep repeating the dose to avoid withdrawal symptoms
- Increasing tolerance and the need for more of the substance to feel its effect
- Social, criminal justice and professional consequences.

Delirium Tremens:

- Withdrawal state from alcohol complicated by delirium
- Can be life threatening
- Short lived

Prodrome:

- Insomnia, tremor and fear

Followed by:

- Clouding of consciousness
- Confusion
- Vivid hallucinations and illusions in any sensory modality
- Tremor
- Insomnia
- Agitation
- Autonomic over activity

Drug Induced Psychosis:

A cluster of psychotic phenomena that occur during or immediately after illicit substance misuse, characterised by:

- Vivid hallucinations often auditory
- Misidentifications
- Delusions and/or ideas of reference often paranoid or persecutory
- Abnormal affect ranging from fear to ecstasy
- Often mild confusion
- Usually resolves within a month