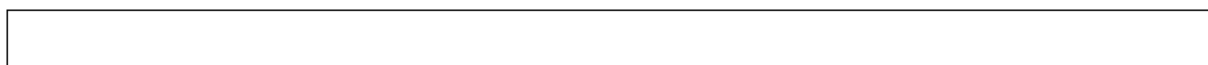
Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol

Parents with severe mental health problems and/ or substance misuse: A framework for safeguarding children



North Wales Multi Agency Protocol

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October 2008	1.0	Original draft document
November 2008	1.1	First consultation document
December 2008	1.2	Second consultation document
January 2009	1.3	Third consultation (medical and substance misuse)
January 2009	1.4	Current version post-consultation
January 2009	1.5	Final amendments following LSCB Exec meeting
June 2011	2.0	Document reviewed by sub group of N Wales Protocols Group
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March 2012	2.3	Changes made after consultation with LSCBs
September 2012	2.4	Changes made following further comments from Gwynedd/Mon LSCB
February 2017	2.5	Introduction of Social Services and Wellbeing Wales Act (2014) Recommendations from Gwynedd ECPR.

Approvals

Name	Approved	Date of approval	Version
North Wales Protocols Group	Approved	07.12.2012	2.4

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Consultation

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Joint Protocol for considering the needs of children when working with adults with severe mental illness and/ or substance misuse

1. Introduction

A "child" is defined here as a person under 18 years of age. This includes unborn children.

For reasons of clarity, the term "parent" refers to those persons with significant child care responsibilities, whether or not they may be the biological parent. The term "parent" is defined more by parental role and responsibility than by familial genetic bonds.

The term "mental illness" will be used in the remainder of this document for reasons of brevity, notwithstanding its association with the medical model. It includes addiction as described in section two.

1.1 The overarching aim of this Protocol is to ensure that the children of a parent(s) with severe mental illness or substance misuse receive appropriate support, safeguarding and protection.

1.2 Agencies have a collective responsibility to protect children. This requires effective communication and co-ordination of services at both strategic and operational levels.

1.3 It is essential that there is close cooperation and joint working by all Agencies involved with the family. This may include Children's Social Care, Health, Education, Police, Probation and the Voluntary Sector. This Protocol provides the framework for joint working to ensure that children living with adults with severe mental illness and/ or substance misuse are safeguarded in North Wales.

1.4 All agencies need to work together in partnership with parents, wherever possible.

1.5 It is recognised that there may be a perceived conflict of interest between the needs of the child(ren) and the needs of [parents with severe mental illness and/ or substance misuse.

1.6 If a child is at risk of significant harm, the welfare of the child is paramount and the *All Wales Child Protection Procedures (2008)* should be followed.

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in order to protect children. Significant harm is defined in the legislation as ill treatment or the impairment of health and development. It describes the effects of sexual, physical, emotional abuse or neglect, or a combination of different types.

Local authorities have a statutory duty under the Children Act 1989 section 47 (1) (b)to make enquiries, or cause enquiries to be made, where they have reasonable cause to suspect that a child who lives, or is found in their area is suffering, or likely to suffer, significant harm.

1.7 Not all parents with a severe mental illness or who use substances are compromised in their ability to provide appropriate care for their children. It is necessary that ongoing assessments are carried out to ensure stability and safety for children living in these circumstances.

1.8 This document is underpinned by legislative framework:

- *The Children Act (1989 and 2004)*
- *The Mental Health Act (2007)*
- *The Human Rights Act (1998)*
- *Mental Health (Wales) Measure 2010*
- *Social Services and Wellbeing (Wales) Act 2014*

All professionals working with adults must consider the impact the adult's presentation/ condition may be having on children in their care. The safeguarding needs of the children must feature within assessments of the adults needs. Any concerns must be referred to by the relevant local authority in line with the *All Wales Child Protection Procedures (2008).*

1.9 This protocol is also to be considered in the context of the Welsh Government Guidance Documents: *Working Together to Safeguard Children (2004); Safeguarding Children: Working together for Positive Outcomes (2004)* and the *All Wales Child Protection Procedures (2008).*

1.10 This protocol should be read in conjunction with the Advisory Council Misuse of Drugs document (ACMD) "*Hidden Harm: Responding to the needs of children of problem drug users" (2003*); updated in 2007.

2. Scope of this Protocol

For the purpose of this protocol, an adult with severe mental illness / disorder is defined as an adult who, following assessment, is diagnosed with one (or more) of the following:

- Schizophrenia or other (enduring or transient) psychosis
- Bipolar disorder
- Severe affective disorder (e.g. severe depression, OCD, anxiety or phobia)
- Severe eating disorder
- Dementia, or other related organic state(s)
- Personality disorder (e.g. anti-social or borderline personality disorder)

For the purpose of this protocol, an adult with problematic substance misuse is defined as:

- An adult who following assessment, is deemed to have a dependency and as a consequence of the above, experiences substantial disability which significantly impedes their ability to live safely in the community without support.

(Based on ICD 10 diagnostic categories)

3. Purpose of this Protocol

3.1 To safeguard and protect children.

3.2 To enable coordinated responses from all services involved with the child and their family.

3.3 To improve communication between and all services involved with the child and their family.

3.4 To ensure the early identification through joint assessment by adult Mental Health and Substance Misuse Services, of those children and unborn children who may be at risk of harm.

3.5 To ensure that the impact of parental mental illness and or substance misuse on parenting capacity is considered with particular emphasis on the impact on the child's development.

3.6 To support effective and well-coordinated service delivery to these families.

4. Risk Indicators

A combination of individual, relational, community and societal factors contribute to the risk of child abuse and neglect. Although children are not responsible for the harm inflicted upon them, certain characteristics have been found to increase their risk of being maltreated. Risk factors are those characteristics associated with child abuse and neglect—they may or may not be direct causes. Several factors can be considered as risk indicators *(Bromfield et al 2010, Bellis et al 2014).*

Risk indicators include:

4.1 *Social exclusion*

Social exclusion involves the lack or denial of resources, rights or goods and services, leading to a reduction in a person's ability to participate in the normal relationships and activities available to the majority of people in a society, whether in economic, social, cultural or political arenas. It is closely linked with poverty and discrimination *(Welsh Adverse Childhood Experiences (ACE) (Public Health Wales 2015).*

4.2 *Domestic Abuse*

Is the emotional, physical, sexual, psychological or economic abuse of power and the exercise of control by an individual or individuals of a family member, partner or ex-partner regardless of gender, age or sexual orientation *(Radford et al 2011).*

4.3 *Mental illness of a parent(s)*

It is estimated that mental illness will affect 1 in 4 of us at some time in our lives. Many children will grow up with a parent who, at some point, will experience mental illness. Most of these parents will have mild or short-lived illnesses which will usually be treated by their General Practitioner.

Few children live with a parent who has a severe mental illness.

Many more children live with a parent who has a long-term problem, such as alcohol or drug addiction, personality disorder or *depression (Royal College of Psychiatrists 2012)*. Problems are more likely to arise if children:

- Are separated repeatedly from a parent who needs to go into hospital.
- Feel unsure of their relationship with the parent with a mental illness.
- Basic needs are neglected
- They are being physically abused
- They are a Young Carer
- They are being bullied or teased by others
- They hear unkind things being said about their parent(s)
- They live in poverty, poor housing or have many changes of home address
- They witness a lot of arguments or violence between their parents

- They live with carers who have a history of not complying with treatment / medication

Research examining the links between child care and mental illness has shown the latter to be a significant factor when considering the safety and welfare of the child. At the very least, it is likely that the quality of parent - child interaction is affected.

Consideration needs to be given to supporting the adult's parenting capacity to in order to meet the needs of their child(ren) *(Manning & Gregoire 2009).*

4.4 *Substance misuse*

Few social issues impact so comprehensively on society as substance misuse. Many children and young people who live with substance misusing parents and carers are suffering its ill effects. They are often neglected, suffer from domestic violence and are at an increased risk of misusing alcohol and illegal drugs themselves.

Research suggests that children who live with substance misusing parents may run a higher risk of having mental health problems themselves, have a greater rate of drug and alcohol use in adolescence, suffer impaired intellectual and academic functioning, have higher levels of anxiety and depression and have lower self-esteem than the norm.

These children may feel different from their peers and may worry that their friends may find out about their parent(s) drug misuse. Therefore, they may miss out on aspects of childhood many children take for granted, for example, having friends visit them at home, and participating in pleasant rituals such as birthdays and Christmas.

However, it is acknowledged that not all substance users have problems with parenting *(Welsh Assembly Government (2008) Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018 Cardiff: Welsh Government).*

In many cases it will be necessary to make an assessment, which includes the substance(s) used and behaviour of the parents, and any impact of this upon their parenting, before deciding what support, if any, is required, and whether the *All Wales Child Protection Procedures (2008)* should be invoked.

Recent Child Practice Reviews and Serious Case reviews have highlighted the rare but dangerous situation when a child has been given substances by his/her parents. Practitioners should be aware of this possibility in a household where substances are abused.

If a child demonstrates any unusual symptoms, emergency medical attention should be sought, such symptoms include:

- drowsiness
- altered level of consciousness
- unsteady gait
- slurred speech
- agitation

(This is not an exhaustive list)

4.6 In many cases it will be necessary to make an assessment, which includes the substance(s) used and behaviour of the parents, and any impact of this upon their parenting, before deciding what support, if any, is required, and whether the *All Wales Child Protection Procedures (2008)* should be invoked.

5 Indicators of distress

5.1 Many children are frightened or worried about their parent's illness or behaviour. Some children withdraw into themselves, become anxious and find it difficult to concentrate on their school work. They may find it very difficult to talk about their parent's illness or their problems at home, which may prevent them from getting help.

Children are sometimes ashamed of their parent's illness and worry about becoming ill themselves. Some children may emulate aggression they witness at home, leading them into conflict with other children, teachers or other authority figures *(Cleaver el al 2011).*

6 Common observable indicators of compromised parenting

- The child's basic physical needs are not adequately met
- The child's emotional needs are not met by a parent who is emotionally unavailable
- Inconsistent or unpredictable parenting due to parental mood swings
- The child receives inadequate or too much supervision for their age
- The child 'looks after' the parent in an inappropriate caring capacity ('parentified' children)
- Health appointments for the child are not kept or appropriate advice is not sought for any health problems the child may experience
- Disruption to the child's education or poor school attendance
- The child's own needs are unacknowledged or ignored by their caregiver
- Unrealistic expectations of a child's abilities
- Unclear boundaries between family roles, with the child assuming a parental role
- Lack of boundaries and routines for the child
- Developmental delay

This list is not exhaustive. Children may present in a variety of ways. This can include a change in their normal presentation.

7 Common emotional consequences of compromised parenting

- Emotional distress leading to disturbed behaviour
- Emotional or mental health problems
- Fearing they may be abandoned
- Fearing their parent(s) may die
- Being afraid their parent(s) do not love them
- Being afraid or ashamed that other people may find out about their parents illness
- Feeling responsible for their parent(s) wellbeing
- Precocious maturity

This list is not exhaustive. Children may present in a variety of ways. This can include a change in their normal presentation.

Passivity due to illness, disinhibition or intoxication due to misuse of substances may allow abusive behaviour to take place, or a child may be exposed to strangers within the home who may present a further risk to them.

8. Assessment of parenting capacity

8.1 All staff working with adults with severe mental illness or substance misuse problems must consider the needs of the child(ren) they are in contact with.

8.2 This must be incorporated into the assessment process and records. This routine assessment of parental capacity aims to determine if the children are at risk.
The assessment format in Appendix 2 should be used by adult services when undertaking an assessment of parental capacity. It concludes with a decision about the level of concerns that the adult worker has about the welfare of the children.

8.3. Where there are concerns about significant harm, a referral must be made as part of the Child Protection Procedures. There is no pre requisite that the parent and child have consented to the referral under Child Protection Procedures. Health professionals who require advice and support can contact the BCUHB Corporate Safeguarding Team and/or their line manager. Line managers should be made aware of any referrals made. Children's Social Care are also available to discuss concerns and offer advice.

On receipt of a referral where there are concerns a child may be at risk of significant harm, Children's Social Care will convene a Strategy Meeting.

Where the referral is submitted under Part 3, Sections 19-29 of the SSWBA (Wales) (2014), an appropriate referral where consent has been obtained will usually be allocated for a Proportionate Assessment. The social worker undertaking the Proportionate Assessment will liaise with other agencies who will contribute to the assessment. Following the Proportionate Assessment, undertaken within 42 working days, further assessment may be required.

A further assessment would focus on parenting capacity and the impact on the child/ren. This assessment should have a multi-agency contribution.

8.4 In planning for the joint assessment by Childrens Social Care and Health, the lead agency should be clarified, and they will co-ordinate the assessment process. In planning for the assessment they should consider the following issues:

- Who will be involved in the assessment, including family members?
- Who will undertake which parts of the assessment?
- Whether there are any communication difficulties, and plans for how they will be overcome.
- Which assessment tools will be used, and by whom?
- What aspects of the assessment have already been undertaken?
- Whether there are any sources of information about the child(ren) or their family not previously contacted.
- Where the assessment will be conducted?
- How the information will be recorded?
- Who will be involved in the analysis and how it will be done?
- What the timescales are for each stage?
- Whether any specialist assessments are required
- Who will undertake direct work with the child(ren)?
- How family members and children will be involved in the assessment?
- Whether the assessment needs to 'co-opt in' any members with particular areas of knowledge and skill, e.g. mental health, drug and alcohol issues

8.5 The lead assessing agency will coordinate the overall assessment process. This involves planning, preparation and coordination with other agencies as appropriate. Discussions will need to take place as to who will be the lead agency, but where there are concerns about the welfare of the children, this will generally be Children's Social Care, with the Adult Mental health/Substance Misuse professionals contributing to the assessment.

9 Assessment of parenting capacity – typical questions and considerations for joint assessment

9.1 The assessment of parenting capacity can help provide an overview of the parent(s) ability to ensure the safety of the child(ren), to provide appropriate emotional warmth, stimulation, guidance, boundaries and ongoing stability.

9.2 The Framework for the Assessment of Children in Need and their families provides the foundation for the systematic assessment of children and families The Framework embraces three key areas: the child's developmental needs; parenting capacity and wider family and environmental factors (q.v *Framework for the Assessment of Children in Need and their families, 2001).*

A child (i.e. a person under 18 years old) is deemed to be "in need" if they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health and development without the provision of services by a local authority.

Figure 1

9.3 Information should be gathered, collated and recorded in such a way that it supports a process of analysis, giving consideration to the 20 domains of the assessment framework *(see Figure 1 above)* using the Comprehensive Assessment Tool for parents and carer *(Appendix 2).*

9.4 The Assessment should include clear summaries in which both strengths and difficulties are identified in each of the three domains *('family and environmental factors', 'parenting capacity' and 'child's developmental needs').*

9.5 This protocol does not suggest that mental health/substance misuse workers should carry out full assessments of children using the three domains (below); rather that the domains provide a useful basis for considering children's needs, and that they should be considered routinely in the assessment of adults with mental health problems. Adult mental health professionals will be particularly valuable in assessing the impact of the parent's mental health in the 'parenting capacity' domain. Assessment is a continuous process and should be updated as new information comes to light. Nevertheless, at the very least there should be an annual review.

10. Care and Support planning and the decision-making process

10.1 In this context, the Adult Mental Health Services Care and Support Plan / Care and Treatment Plan is the ‘jointly agreed plan’, which is derived following consideration of the holistic assessment of the family’s needs, with the child’s needs being of paramount importance.

10.2 Following the Joint Planning Meeting, each Care and Support Plan / Care and Treatment Plan will identify clear objectives, responsibilities and review dates.

10.3 It is essential that there is good communication and joint planning to support appropriate and integrated service responses. Consultation should always occur between families and teams on significant changes in Care and Support Plans / Care and Treatment Plan and on the planned closure of a case. Children’s services should always be informed if there are any significant changes in a family which may impact on parenting, for example, if a parent or carer leaves the household, leaving the other parent who suffers from mental illness with sole care of the children. Equally, Children’s services must always be informed if there are plans to discharge a parent / carer from acute psychiatric care.

10.4 In cases where there is not an allocated Social Worker or Care Coordinator for the parent, the relevant Team Manager from the Mental Health Service/Substance Misuse Service will ensure advice and consultation to Children’s Services along with undertaking the liaison function.

10.5 Alternatively if there is not an allocated Social Worker for the child(ren), the relevant Team Manager from Children’s Services will ensure the team provides advice and consultation to the Mental Health Team/Substance Misuse Service. Each authority should consider holding regular meetings between relevant Team Managers to facilitate this process.

10.6 If any person has knowledge, concerns or suspicions that a child is suffering, has suffered or is likely to be at risk of harm, it is their responsibility to ensure that the concerns are referred to the relevant local authority and or the police *(All Wales Child Protection Procedures 2008).*

10.7 Any Care and Support Plan / Care and Treatment Plan developed under this protocol must be referred to, and included within, the Mental Health Measure Planning process *(Mental Health (Wales) Measure 2010).*

11. Making a referral to Children's Social Care from Adult Mental Health/ Substance Misuse Services

11.1 If an AMH/SM worker is worried about a child's welfare a prompt referral should be made to Children and Families Services. If the practitioner is unsure then further advice can be sought from the BCUHB Corporate Safeguarding Team.

Referrals can be made by telephone to the duty Social Worker and must be followed up with a written referral form within 24 hours.

11.2 As much information as possible should be provided in the referral, all sections should be completed where possible.

- Reasons for referral/concerns
- Family details, siblings, other significant family associates.
- Schools attended
- GP
- Parents diagnosis ,severity ,risk ,history, compliance with therapy & medication
- Insight into the child's needs
- Impact on parenting capacity
- Whether the child or family have consented to being referred, highlight child protection referral or care and support referral.

11.3 Where appropriate, Children's Social Care will undertake a Proportionate Assessment within 42 working days and will carry out a Section 47 investigation, where it is found that parental illness/drug misuse may cause a child to be at risk of significant harm. This could be a child:

- Who features within parental delusions
- Who is involved in his or her parent's obsessional compulsive behaviours
- Who becomes a target for parental aggression or rejection
- Who has caring responsibilities inappropriate to his or her age
- Who may witness disturbing behaviour arising from the mental illness (e.g. self-harm, suicide attempts, uninhibited behaviour, violence)
- Who is neglected physically and/or emotionally by an unwell parent
- Who is at risk of physical injury or chronic neglect

11.4 A pre-birth comprehensive assessment should be undertaken by Children's Social Care on all referrals of pregnant women or male service users with a pregnant partner, where the degree of parental mental illness/impairment or substance misuse is likely to impact significantly on the baby's safety or development. There should be a multi-agency contribution to the assessments inclusive of, comprehensive assessment tool for parents and carers and health pre-birth comprehensive assessment.

Multi-Agency Pre Birth Pathway (2016)
http://www.northwalessafeguardingboard.wales/policies-and-procedures-children/

12. Children's Social Care response to a referral from Adult Mental Health/Substance Misuse Services

12.1 Once a referral is received, Children's Social Care will check whether or not the child(ren) are already allocated to a Social Worker. If the child is already an open case to Children's Social Care, the allocated worker will be informed of the referral immediately.
The allocated worker will then liaise directly with the referrer.

12.2 If the child is currently not an open case, further checks will be undertaken and a decision made as to what further action is necessary within 1 working day.

12.3 If child protection procedures are to be followed:

- Children's Social Care will undertake a Strategy Meeting in order to decide whether to commence a Section 47 investigation. The Strategy Meeting takes place within 24 hours.
- The AMH/SM worker should attend the strategy meeting to ensure joint planning and assessment takes place
- It may be appropriate for a joint home visit to take place as part of the S47 Enquiries.
- Children's Social Care should inform the AMH/SM worker of the outcome of the
- Section 47 investigation
- Children's Social Care will invite relevant representatives of Adult Mental Health or
- Substance Misuse services to the Initial Child Protection Case Conference

12.4 If a 'Children in Need of Care and Support' response is appropriate, Children's Social Care will:

- Undertake a Proportionate Assessment
- Invite the AMH/SM worker to contribute to the assessment and attend any planning meetings to ensure joint planning and assessment takes place
- Conduct a joint home visit with the AMH/SM worker or other involved professional
- Require all agencies to contribute to the assessment, the development of a Child in
- Need of Care and Support plan and subsequent reviews
- Always inform the AMH/SM worker if the case is to be closed

12.5 The status of cases at child protection or children in need of care and support can change over time once new information has been received or decisions made.

13 Children’s Social Care referrals to Adult Mental Health /Substance Misuse Services

13.1 Children’s Social Care staff with concerns about the mental health/substance misuse of a parent/carer should establish if they are receiving or have received any services from their GP or Adult Mental Health/Substance Misuse services. A referral to Adult Mental Health services must always be considered when there is a current or past diagnosis of psychosis.

13.2 Children’s Social Care staff should state their concerns explicitly, providing an accurate description of presentation, behaviour and impact on parenting capacity. The details of the family composition should also be recorded.

13.3 Urgent Mental Health assessments for new referrals

The AMH worker will:

- Receive the referral via the GP and allocate to the duty person in SPOAA. The duty person will research and gather all available information from services and this information will be presented at the mental health single point of access meeting for discussion and case management decision the following day. Part of this management plan will be to acknowledge receipt of the referral within 24 hours with the GP and any children’s social service staff involved and state the actions taken in response.

- Use Mental Health Measure documentation Parts A, B and C. The AMH worker will assess mental health needs, risk and formulate an appropriate risk management plan within 10 working days.

- If there is immediate risk to self or others a formal Mental Health Act assessment must be considered.

- Children’s Social Care to be informed within 24hrs of the outcome of the assessment.

- If the outcome of the assessment results in an assessment under the Mental Health Act Inform, Children’s Social Care should be informed immediately to enable the assessment to be co-ordinated to ensure appropriate care of the children.

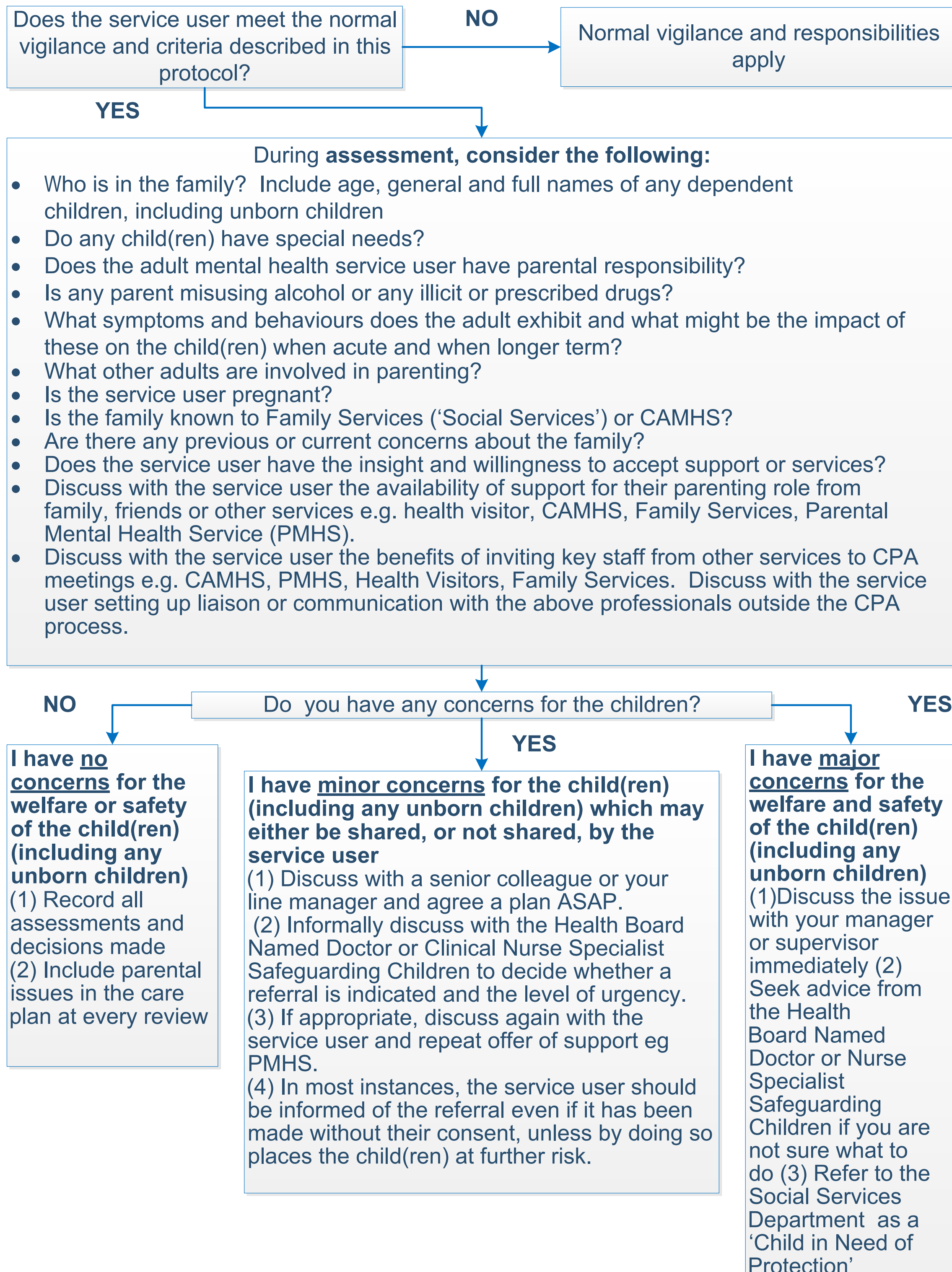
- AMH worker will agree a joint care plan with Children’s Social Care if the carers/parents are to remain at home. Joint visit and / or meetings should be arranged between Children’s Social Care and the care co-ordinator. Any changes from either service are to be communicated within 48hrs or immediately if there is a risk posed.

- Children’s Social Care should be immediately if the carer/parent is to be admitted either as a formal or informal patient, so that alternative child care arrangements can be made in a planned and timely manner.

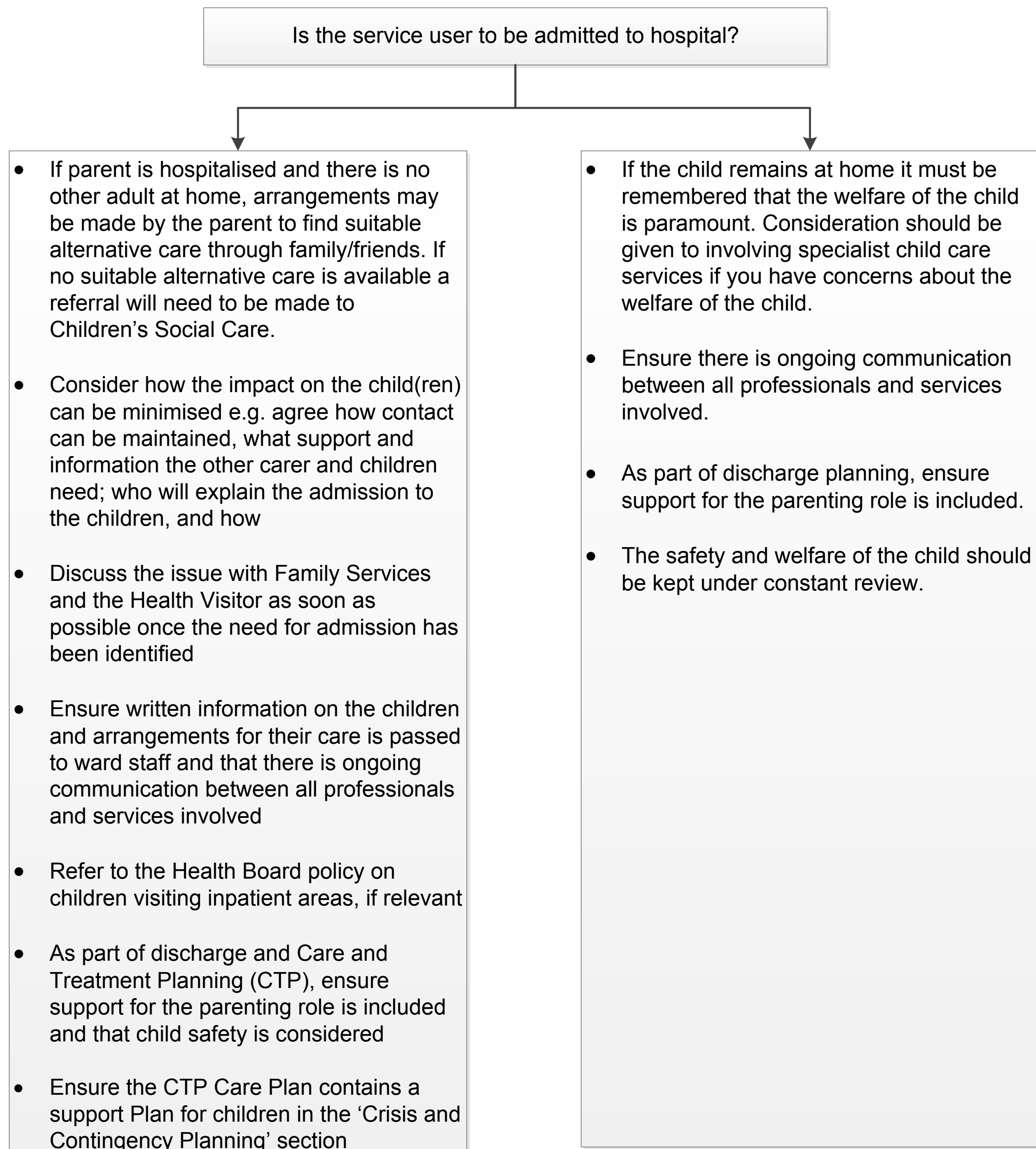
14. Working with other Agencies

14.1 A number of professionals from a variety of agencies may be involved e.g. Health Services / Primary Care, Education, Police, Probation and the Voluntary Sector. Consideration must be given to securing multi-agency representation at Joint Planning Meetings.

15 Decision support: Parents in crisis



15. Decision support: Parents in crisis



NB Children whose parents have severe mental health or addiction problems will usually be 'children in need of care and support' in their own right.

As part of the assessment of an adult with mental health problems practitioners need to consider how the service user's presentation impacts on their children or on those children with whom they have regular contact.

In all cases where there is a conflict between the welfare of the child and the rights of a parent or carer, the welfare of the child is paramount and takes precedence.

Appendix 1 – Initial /Review Conference Report

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

CONFIDENTIAL **REPORT FOR *Initial/Review CHILD PROTECTION CONFERENCE** (*delete as appropriate)	
Prepared by:	**Designation:**
I *will/will not be attending (*delete as appropriate)	
Date of Conference:	**Venue:**
Local Authority Area:	

Names of Children:	**Sex:**	**Date of Birth:**	**School:**
Address:			

Siblings (if not subject of report) and address if different:				
Name:	**Sex:**	**Address:**	**D.O.B.**	**School**

Parents:			
Mother:		**D.O.B.**	
Father:		**D.O.B.**	
Parental Responsibility:			
Address (if different):			

Significant others:			
Name:	**Address**	**D.O.B.**	**Relationship:**

Name of GP/Surgery:	
Registered with Dentist:	**Yes [ ] No [ ]**
Key Worker:	

Other professionals involved:	
Name:	**Agency:**
<u>If a Review Conference:</u> **Date of Registration:** **Category:** **Date of last case Conference:**	
Background Information/Reason for Conference:	
Child's Developmental Needs:	

Hospital Attendances/Admissions:		
Immunisation status:		
Parenting Capacity:		
Family and Environmental Factors:		
Analysis of key issues:		
Identified Needs:		
Current or planned Intervention:		
Strengths:		
Risks:		
Recommendations for registration (with reasons):		
Signature:		
Name (please print)		
Designation:		
Date:		
Base Address:		
Report shared with parents/ young person:	**Yes [ ]** **No [ ]**	**Date:**
If No Reason:		

Appendix 2 - Comprehensive Assessment Tool for use by Adult Mental Health and Substance Misuse Services

Mental Health & Learning Disability
Holistic Assessment Tool for Parents & Carers
(To be used for all parents & carers who are responsible for children and for the assessment of unborn child)

Framework for the assessment of parenting capacity
Assessment Framework

- *The Framework for the Assessment of Children in Need and their Families (2001)* embraces three key areas: the child's development needs: parenting capacity and wider family and environmental factors.

- All staff working with adults with severe mental illness or substance misuse problems must consider the needs of the child(ren), giving consideration to the 20 domains of the assessment framework.

- This tool does not suggest that workers should carry out full assessments of children using these above three domains but that the domains provide a useful basis for considering children's needs and that they should be considered routinely in the assessment of adults with mental health/substance misuse problems.

Personal Details

Name:	**Address:**
DOB:	**Contact No:**
Partners Name: **DOB:**	**Partners address:**
GP:	**Health visitor:** **School Nurse:**

Children/unborn: **Name:**	**DOB/EDD:**	**Relationship**	**Who has parental responsibility**

Family and environmental factors:

Health Issues **To consider:** Details of substance abuse i.e. type, quantity and administration of substance. Is the substance use stable, recreational or chaotic? Is the person engaging in treatment? Does the person have a mental health problem? Is there history of self-harm, suicide attempts or repeated admissions into hospital? Is there a history of postnatal depressions? Does the person have any current medical problems?
Family history & functioning **To consider:** Details of partner and whether they have a substance abuse problem/ mental health issues. Are there any disclosures of Domestic Abuse? Do parents have support from family and friends? Are others within the family known to services? Any criminal activity? Are the child(ren) isolated from extended family?
Housing **To consider:** Is the accommodation adequate and safe for children/ new baby? What are the storage arrangements for medication and hazardous substances? Does the family move frequently or share accommodation with others known to services? Are there concerns about the frequency or number of visitors to the home?

Employment/ income

To consider:
Is one or both of the parents in employment? Are there any financial difficulties? What benefits are being claimed? Is support needed with application forms?

Family social integration/ community resources

To consider:
What activities/ groups are the family involved in? Are they known to other services? Give contact details. Is this child/ young person accessing universal services – play, youth, etc.?

Parenting capacity:

Provision of basic necessities

To consider:
Ensuring basic care, safety, emotional warmth, stimulation, guidance/boundaries & stability for example – Is there adequate food, clothing & warmth for the child(ren)? Is there appropriate toys in the home? Are the child(ren) attending school regularly – check & document liaison with school nurse or Education Welfare Officers. Identify Name of school and address that children attend. Are the child(ren) engaging in age appropriate activities or assuming parental responsibilities? Are the child(ren) known to Social Services? If so document the name of the Social Worker & outline plan of care. Have the child(ren) ever been separated from their parents & for what reason? If the child(ren) were to wake up in the night would their needs be met? Are there signs the person is struggling with parenting? What safety precautions exist for the care of the children?

Childs developmental needs:

Pregnancy **To consider:** Is the woman accessing health care? Document contact details of midwife, Specialist Midwife & Health Visitor. Has relevant information been given regarding mental health/substance misuse/pregnancy including health risks to both her & unborn baby? Does her partner have a mental health or substance misuse issue, if so, is he in services? Has the woman started to prepare for the birth of her baby? Has a Planning/Professional's meeting been held?
Child health **To consider:** Are there any health concerns? Does the child have a disability? What services are involved? Are developmental goals being achieved and immunisation programmes being met? Liaise with health visitor. Do the child(ren) present appropriately, for example clean & Tidy? Has the child(ren) been seen? If so were they seen alone?

Plan of action:

Action	**Yes (tick below)**	**No (tick below)**
Discuss with team manager?		
Action required?		
Are the child(ren) in need of Care & Support		
Has consent been given for referral		
Are the child(ren) at risk?		
Have you made a referral to Children's Social Care? (if yes please note date/ time & to whom referral was made)		
Is there a disclosure of Domestic Abuse?		
Have you completed the HITS?		
What was the HITS Score?	1 2 3 4	
Have you completed the Safe Lives RIC? What was the score?		
Have you made a MARAC referral? (if yes, please note date/ time & to whom referral was made)		

Full name (print):	
Signature:	
Designation:	
Date completed:	
Copy sent to:	

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