Think Family Toolkit
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**What is Think Family?**

**Think Family** is an approach to help practitioners consider the parent, the child and the family as a whole when assessing the needs of and planning care packages with a parent suffering from a mental health problem.

Mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked in at least three ways:

- Parental mental health problems can adversely affect the development, and in some cases the safety, of children;

- Growing up with a mentally ill parent can have a negative impact on a person’s adjustment in adulthood, including their transition to parenthood;

- Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers.

The Think Family toolkit has been introduced to support the Devon and Torbay Safeguarding Children Board Think Family Protocol

**Want to know more?**

Torbay Safeguarding Children Board Think Family protocol

Devon Safeguarding Children Board Think Family protocol
Sarah is a 42 year old mother of three children. Jessica, 17, is studying for her 'A' levels. Phillip, 16, is studying for his 'O' levels and Poppy, 8, attends the local primary school. Sarah’s partner, Joe, father of her three children, is supportive, but he is in the armed forces and spends long periods away from the family.

Sarah had post-natal depression following the birth of Poppy and has never returned to her career as a teacher. She has anxiety disorder. Sarah has frequent panic attacks and is often unable to leave the home.

Sarah has been hospitalised in the past and her biggest fear is to return to hospital.

Sarah is supported in the Community by her GP, CPN, Consultant Psychologist, Health Visitor, School Nurse, the Pastoral Care Officer at Jessica and Phillip’s school, the Head Teacher for Poppy and the Armed Forces Welfare Service. She also has support from her family, although they live 300 miles away, and from local neighbours and friends on the military estate they live.

The number of professionals working with Sarah and her family is overwhelming for her; in itself raising anxiety and panic attacks. She often fails to get to appointments and then feels a failure.

Julie, the CPN, has worked with Sarah for 3 years and has seen little change. Julie decided to take a different approach to working with Sarah, and felt by taking a 'family' approach professionals could work together. The whole family attended the meeting, with Sarah being supported by Joe and the children.
Each family member was offered the opportunity to say what they 'needed' from each other and from professionals. Sarah was able to describe how overwhelming she found all the professionals and the demands made upon her and the feelings of failure when she was not able to achieve things.

Very few of the professionals were fully aware of Sarah's mental health. Poppy's Head teacher had no awareness of Sarah's mental health.

A 'Family' plan was drawn up which Sarah felt was manageable and met the children's needs. The plan included:

- Sarah would have one identified professional to coordinate appointments and relay these to her.
- Appointments about the children would, wherever possible, occur when Joe was at home.
- The children to be provided with phone numbers so they could contact professionals (CPN and welfare officer).
- The CPN to liaise two weekly with Joe and the children (with consent from Sarah).
- Professionals would meet together with the family six weekly.

**Outcome**

At the onset, all the professionals were positive about the approach and wanted to support the plan. The plan continued for twelve months with Jessica and Phillip successfully completing their studies. Jessica is now preparing to go to University and Phillip for his 'A' levels.
Sarah’s liaison with one professional has helped her cope with appointments for herself and the children, although, she continues to have panic attacks, her diary shows great progress and she has managed to leave the house and attend some of her appointments and those for the children.

Sarah talk more positively about the future, she has set herself targets over the coming months with trips to the park with Poppy, settling Jessica into ‘halls’ and is even talking of a short family holiday.

Sarah believes the family meeting was the beginning of real change - that all the professionals were in possession of the same information and she did not have to repeat her ‘story’ each time she came in to contact with them, which reinforced her feelings of failure.

Her children’s access to professional support also provided Sarah and Joe with reassurance, for Joe he knew the children could quickly get support for themselves and for their Mum, for Sarah, she felt her children were being supported. In reality, the children never needed to contact anyone as they regularly saw Julie and had access to support at school.

Joe has been posted to a local base for the next five year, where he will finish his career. He is also talking more positive about family life and making plans for himself and Sarah.

Poppy is now described as a chatty little girl, who is making friends and achieving at school and talks about family life to her teacher and Head Teacher.

The family believe a ‘Think Family’ approach really helped them to make changes and are positive about their future, individually and as a family going forward.
How can I Think Family?

Make small changes to your practice

➢ Recognise them as a parent / carer

Ask the adult if they are a parent or main carer for a child or young person when you first meet them

Record details about the child on the adult electronic record

When making appointments consider their role as a parent - see the person during the day if they parent school age children

Ask if they have someone to provide childcare for pre-school age children

➢ Consider the impact of their mental illness on their parenting

Are they prescribed medication that will affect their ability to parent?

Is the symptoms of their mental illness a risk to the child?

“Taking an interest and asking about the children and looking at photo’s took away the woman’s fears that her children would be removed because she was depressed”

Adult Mental Health Family Practitioner

“A plan was put in place for the grandparents to look after their grandchildren at weekends to support their daughter when she became unwell”

Adult Mental Health Family Practitioner
Parents most often want what is best for their children. Good information sharing is a fundamental element of successful multi-agency working and a crucial protective factor for children.

**Sharing information with consent**

Research tells us most parents are happy for professionals to talk to each other. When you are working with an adult who is a parent, have a conversation with them at the onset of your involvement about sharing their information. Find out what other professionals are working with the family, agree with the adult what information to share, give your reasons for wanting to share information. Obtain a written agreement which can be placed on their file and refer to in the future.

Wherever possible encourage the adult to share their own information and contact professionals working with their children. Schools and nurseries offer support to children and their parents when they are kept informed.

**Sharing information without consent**

There are some circumstances that you have a statutory duty to share information even without the parent’s consent. If it is your professional judgement that their mental health, lifestyle choices, or other factors is affecting their parenting and the child is a risk of harm, you will need to share this information with Children’s Services. Even if they do not agree to you sharing the information, wherever possible explain to them your reasons for doing so. If telling the
parent could put the child at further risk you may decide to talk to Children’s services without getting the agreement of the parent or informing them of your decision. You must record your reasons for doing so in the electronic record.

Want to find out more?

Devon Partnership Trust Information Sharing Policy

Information sharing; guide for practitioners and managers (March 2015)

How to identify which rules apply when sharing information

Information Sharing – How to record decisions

How to seek consent to Share Information

Working together to safeguard children (2015)

What to do if you are worried a child is being abused

Child Protection Information Sharing Project
http://www.england.nhs.uk/2014/03/21/ch-protect/
National Service Framework

The National Service Framework for Mental Health (1999) provides a framework, which can assist in better provision for patients who are parents. For example, it provides all mental health practitioners with opportunities to:

- Promote mental health and engage in earlier intervention/prevention (Standard one). Knowing which patients are parents will enable appropriate steps to be taken for the patient as parent and for her/his children;

- Improve links with Primary Care where the bulk of maternal depression/anxiety will present and where closer collaboration with the range of community-based children's services can occur;

- Support carers (Standard six). This should be interpreted as applicable to all carers: those who care for individuals experiencing mental illness; young carers who look after a mentally ill parent/carer and those who are themselves experiencing mental ill health and who also care for dependent children.

Framework for Assessment of Children in Need

The Framework for Assessment of Children in Need and their Families (2000) provides an approach to assist Children's Social Care Services to undertake systematic assessments of the needs of the child and parental capacity to meet those needs. It recognises the role of social adversity and mental illness as stress which could affect parenting. It emphasises the importance of collaboration between services and agencies at all stages of the assessment and in
intervention. It will therefore help to identify gaps in provision and provide opportunities for establishing better links between childcare and mental health services.

**National Patient Safety Agency**

In May 2009, National Patient Safety Agency (NPSA) issued a Rapid Response Report (RRR) to all Mental Health organisations asking them to make changes to how their staff consider and act on any risks to the children of adult service users.

All NHS Trusts need to be compliant with the principles of this NPSA report regarding safe discharge of mentally ill patients and encompassing in the discharge plan's and CPA's any risks for the children.

**Want to find out more?**

National Service Framework for Mental Health (1999)

Preventing harm to children from parents with mental health needs (NPSA Rapid Response Report, 2009)
[http://www.nrls.npsa.nhs.uk/resources/?entryid45=59898](http://www.nrls.npsa.nhs.uk/resources/?entryid45=59898)
THINK CHILD

- Who are the Children?
- What is their story?
- Is the child a young carer?

THINK PARENT

- How does their mental health impact on their ability to parent?
- How does their parenting responsibilities impact on their mental health

THINK FAMILY

- Include any actions for the child in the adult plan
- Share information with other professionals working with the family

A successful service for Families with a parent with a mental health problem and/or a alcohol or drug dependency will:

- promote resilience and the wellbeing of all family members, now and in the future
- offer appropriate support to avoid crisis and to manage well if a crisis arises
- secure child safety

HM Government (2009)
What Children need

Children and young need nutritious food, warm clothes, bedtime at a reasonable hour, opportunities to develop socially and learn new skills. Additionally, they need to socially engage with peers, experience praise and have appropriate discipline to develop self-confidence, high self-esteem, stay physically healthy and have a healthy emotional outlook on life.

General health
- In good health with no medical conditions
- Good oral hygiene
- Access to and use GP, dentist, health visitor, optician
- Health needs are met i.e. immunised, medication provided, hospital appointments attended
- No unintentional injury requiring GP/hospital treatment of unborn baby, infant, child or young person

Physical development
- Good balanced diet - five a day
- Developing well e.g. height, weight, hearing, sight
- Good hand-eye coordination i.e. drawing, tying shoelaces
- Crawling, walking, running, playing
- Fit and active
Speech, language and communication
- Reading and writing at appropriate level for age
- Listens and understands
- Talks and responds appropriately
- Interacts well with others and makes good friends
- Development of unborn baby, infant, child or young person

Emotional and social development
- Strong attachment and bond between parent and child
- Feels loved, valued and respected and shows these in return
- Happy and positive attitude to life
- Recognises emotions and display them appropriately
- Communicates well with others including sharing of emotions

Behavioural development
- Well behaved at home and in other places
- Understands consequences of actions
- Good attention span – listens and is attentive
- Displays appropriate behaviour with friends
- No unnecessary or unsafe risk taking behaviours i.e. drugs and alcohol, sexual activity

Identity, self-esteem, self-image and social presentation
- Knows who family members are
- Good self image which is shown appropriately
- Self esteem not too low or too high
- Has a sense of belonging within a particular group
Risk Factors for Children

Babies up to 1 year old
- Inability of the parent to respond and nurture
- Lack of warmth
- Negative responses
- Poor attachment
- Inconsistency/ chaotic parenting - child poorly clothed - hungry
- Not reaching developmental milestones

Young children
- Behavioural problems - lack of boundaries
- Anxiety and withdrawal
- Conduct disorder
- Aggression towards family and/or peers
- Inconsistency/ chaotic parenting - child poorly clothed - hungry
- Not reaching developmental milestones

Adolescents
- Increased risk of developing a mental health problem
- Behavioural problems
- Conduct disorder
- Depression
- Difficulties at school - poor attendance
- Difficulty with friendships
- Running away - Child Sexual Exploitation
Think Family requires the adult mental health professional to consider the impact of parental mental ill-health or drug and alcohol use on the adult capacity to care and keep safe their child from harm or neglect. The professional should consider the needs of the child at each contact/intervention with the adult receiving services and take appropriate action as required.

People with mental health issues can experience changes/difficulties with the way they think, feel or behave. Parental mental ill health can, in some circumstances, lead to an inability to look after the child’s physical and emotional needs. Children who have mothers with mental health issues are five times more likely to have mental health problems themselves.

Problem drug use in the UK is characterised by the use of multiple drugs, often by injection, and is strongly associated with socio-economic deprivation and other factors that may affect parenting.
capacity. It is typically chaotic and unpredictable. Serious health and social consequences are common.

Parental mental ill health, alcohol or drug dependency holds specific risks for children of particular age groups.

It is important not to assume that all children or young people will have problems just because they grow up living with a parent who has mental ill health or dependency. Research has shown that the adverse effects on children and young people are less likely when parental disorders are mild, last only a short time, are not associated with family disharmony and do not result in the family breaking up. Children may also be protected from harm when the other parent or a family member can respond to the child’s needs, and the child or young person has the support of friends and other caring adults.

**A Framework for assessing risk**
The assessment of parenting capacity to protect children from risk is a core task when assessing an adult with mental ill-health, drug or alcohol dependency who is a parent. Assessing parenting capacity will help professionals to understand the extent to which an infant, child or young person’s physical needs are met; that they are protected from harm or danger, including self-harm. The professional must also consider how far the child or young person is safe from harm or sexual exploitation.

The Impact of parental mental illness on children’s needs
The impacts on children with a mentally ill parent/carer range from no adverse impact to the extreme of child death.

The child of a mentally ill adult can be affected as a result of specific symptoms or characteristics of a disorder or disorders that the parent is experiencing including:

The nature, severity and duration of the parental illness
- How does the illness intrude of parental functioning?
- Can the symptoms and behaviours affecting the child be modified?
- Are the symptoms and behaviours pervasive, affecting all aspects of parenting?
- How does the pattern of the illness affect parenting?
- What length of time has the parent suffered from the illness? How long do each episodes last? When have episodes occurred in relation to the child’s life-span?

Co-morbidity and dual diagnosis
- Negative impacts on the children are more likely when a parent
suffers more than one mental illness at a time, e.g. depressions, personality disorder and alcohol or drug abuse or mental illness and learning disability.

The child’s involvement in and exposure to parental symptoms

- This can happen in a number of ways, and should always be explored and assessed, particularly if children are incorporated into a parent’s delusional thinking or thoughts of self-harm, or are the direct or indirect target of violent behaviour.

The effects of treatment, including non-compliance

- Treatment may have side effects which impinge on the parent’s capacity to carry out parenting tasks, e.g. anti-psychotic medication causing lethargy and drowsiness.
- Consider if the adult is complying with recommended treatment. This may have implications for their parenting if successful treatment could benefit their parenting capacity.
- Explore the reasons for non-compliance - is the adult experiencing unpleasant or inconvenient side-effects? Does the person have insight into their illness and treatment? Is the person’s treatment plan in accordance with any cultural, religious or ethnic needs?
- Explore effective alternatives.

Any effect that the mental illness has on the parent’s social and psychological functioning, particularly their capacity to relate to and parent their child

- The child may not be exposed to the adult’s symptoms, but is nevertheless affected by changes in the adult’s capacity to parent, e.g. the adult is less emotionally involved with the child as a result of their illness.
- The affect on the parent-child relationship and the child’s emotional and behavioural development.
Associated alterations in family structure and functioning

- Does the child take on a caring role?
- What is the impact on the child of separation and loss when a parent is hospitalised?
- What alternative arrangements are made? What is the impact on the child?
- What is the attitude of the extended family to the illness? What impact does this have on the children?

Associated Risk factors

- Adverse / abusive childhood experiences
- Absent or discordant partner relationship
- History / current experience of Domestic Violence
- Poor / insecure housing
- Multiple significant life events – bereavement, loss
- Experienced poor / disturbed parenting as a child
- Poor physical health /disability
- Lack of employment
- Experienced parental mental illness / drug or alcohol dependency as a child

Protective factors

There are generic risks associated with substance misuse including; health risks around intravenous drug abuse and use of needles risks around children, accessing and ingesting drugs. There is also an increased risk to children of physical and sexual abuse from visitors who attend the household of drug using or mentally unwell parents.

Associated Protective factors

- Positive parenting as a child
- Secure attachments to parents
- Harmonious and mutually supportive relationship with partner
- Good physical health
- Supportive network of friends and community
- Secure and well-maintained housing
- Financial security
Domestic Violence and Mental Health

There is a clear link between domestic violence and mental ill health: abuse - both in childhood or adult life - is often a precursor of and a causal factor in the development of mental health issues, including depression, post-traumatic stress disorder and self-harming behaviour.

Domestic Violence is experienced by men and women, in heterosexual or same gender relationships, across all cultures and class.

- Violence against women is probably the most prevalent cause of depression in women, and of other mental health difficulties.
- Domestic violence, rape and sexual assault also commonly result in self-harm and attempted suicide.
- One-third of all female suicide attempts are by women experiencing domestic violence.
- Women mental health service users are much more likely to have experienced domestic violence than women in the general population.
- Male victims are nearly twice as likely than women to not tell anyone about partner abuse.
- 10 adults each month die as a result of Domestic Violence - 7 women and 3 men.

Domestic Violence and Substance Misuse

Women who misuse alcohol and other drugs are more likely to have been abused, both in childhood and adult life, than women generally. The substance misuse seems more likely to be in response to the
abuse, rather than a causal factor, and it is suggested that women who have experienced abuse may turn to alcohol as a way of deadening the pain: a self-prescribed medication (Ettorre, 1997).

Asian women’s use and misuse of alcohol is most often associated with other problems, including isolation and marital difficulties (including violence: 42% of clients at one Asian counselling service experience domestic violence). Similarly, women drug users have a high incidence of trauma, and as many as 70% may have experienced abuse.

Women who misuse substances are in a particularly vulnerable position, and are likely to find it even harder to report domestic violence than other women.

**Domestic Violence is a Serious Risk Factor for children**

Domestic Violence in a household puts a child at a high risk of harm: research tells us that children are at significantly higher risk to all forms of child abuse when Domestic Violence occurs in their home.

A child does not have to be hit to be harmed:

- witnessing Domestic Violence can impair a child’s development

- In a family where there is a child under 12 months old (including an unborn child), even if the child was not present, any incident of Domestic Violence should trigger a Child Protection Investigation

130,000 children live in households where Domestic Violence occurs.

52% of children subject to a child protection plan have witnessed domestic violence.
Risk Factors for children

- possible previous experience of violence in the home (remember this can increase vulnerability or risk but not necessarily cause someone to become a perpetrator or victim)
- a naïve or distorted view of relationships and/or gender entitlement
- low perceived control
- depression
- poor mental health
- drug and alcohol misuse
- school non-attendance
- homelessness
- disruption of the family unit
- sexual relationships
- having a child
- poverty
- sexual exploitation and sexualised risk taking.

Protective factors

- achievement at school;
- a safe haven;
- support from positive role models/friends/mentors
- the belief that others have high expectations of them
- physical, emotional and economic security
- decision-making capabilities
- assertiveness (internal and external)
- awareness of legal rights
- awareness of how to form healthy relationships.
Young People and Domestic Violence

Young women aged 16-24 are the group at highest risk of experiencing domestic violence.

Young people are more likely to experience abuse from peers.

Adolescents can be more accepting and dismissive of abusive behaviour than their adult counterparts.

Signs an adolescent may be experiencing Domestic Violence

- physical signs of injury
- truancy and/or dropping out of school
- failing grades
- changes in mood or personality
- use of drugs/alcohol (where there was no prior use)
- emotional outbursts
- isolation from friends and family
- very frequent texts and phone calls from a partner
- presence of sexually transmitted infections (due to sexually risky behaviour as a coping mechanism)
- pregnancy (either unintended due to poor use of, or absence of, contraception, or intended in order to escape the situation).

Want to know more?

Safe Lives
http://www.safelives.org.uk/about-us

Improving Safety, Reducing Harm (HM Government 2009)
http://www.avaproject.org.uk/media/140961/dh%20improving%20safety,%20reducing%20harm.pdf

Sane Responses: good practice guidelines for domestic violence and mental health services (2008)
Think the Unthinkable

As workers, we should always work with 'healthy scepticism' when dealing with families where children might be at risk.

Asking parents and families how they parent is not always the most reliable way of finding out what is happening in the home. Watching parenting in action (setting boundaries, play between parent and child) can be much more informative.

Research tells us:

- 75% of parents do not cooperate with services - includes disguised compliance and telling workers what they want to hear (Biennial Review of SCRs 2005-2007)
- Though not consciously, parents often test the resolve of the safeguarding and child protection systems (Haringey SCR, Peter Connelly, 2009)

A Seen Child is Not a Safe Child

Almost every child who has been subject to a serious case review over the last 40 years was 'seen' by a professional within days (or hours) of their death.

Simply seeing a child is not protection against harm. Workers need to try to understand what the world looks and feels like for that child.

Getting a narrative of the child's day-to-day experience is a good place to start rather than getting them to answer yes/no questions.

Assessment is a Process, Not a One-off Event

Assessment is about forecasting the future by reviewing past events. Review your thinking as new things happen - assessment should be ongoing; it doesn't end when a formal assessment has been completed.
We assess in order to make an appropriate plan, to implement that plan and to review how well its objectives have been met, and then to keep assessing.

Past experiences have a critical impact on present and future behaviour. Your understanding of a person’s history must inform your assessment.

Assessments should not be carried out in isolation - we need to share information effectively and should always ensure we let others know what we know and what we are doing, as well as checking out what they know and what they are doing.

**Interaction is NOT the same as 'Attachment'**

Parents may overcompensate or put on a display for strangers - but parents tend not to be able to 'fake it' for more than a few minutes. Why not ask them to play with their child and during the play demonstrate how they place boundaries.

Don't assume that a child has a secure attachment style because they are smiling. Determining the quality of attachment is a skilled and sometimes prolonged task.

Many children who are abused are compliant and eager to please. Often even very young children are torn between trying to protect their parents from detection by the authorities and protecting themselves.

**Questions to consider are:**

- What is the quality of the parents' responsiveness to the child?
- What evidence have you observed in the child's behaviour that suggests secure, ambivalent, avoidant, disordered?
- What research supports your view?

**Neglect is a Relationship Issue**

Neglect (nits, poor hygiene, weight loss, lack of supervision, etc) may signal a poor adult-child relationship. All neglect stems from parents prioritising something else over the child’s basic needs.
Workers sometimes become too tolerant of high levels of neglect and fail to spot risk.

**Questions to consider are:**

- What is going on in the relationship between the parent and child that has allowed this to happen?
- Where do the parents' priorities lie?
- Does the parent have a sense of the child's 'otherness'?
- How aware is the parent of the child's needs, personality, strengths and struggles?
- What is it like to be that child's age and living in that household?

**Consensus Isn't Always Safe**

The fact that everyone agrees does not mean that they are right - and certainly does not keep a child safe.

There is no safety in numbers - risk does not decrease because more people agree.

Minority views are important and must be considered and noted within multi-agency work. Consider what it is about that worker's experience that differs from others'

**Parental Participation is NOT the Same as Cooperation**

Don't confuse an apparent willingness to comply with an actual willingness to accept the need to change.

The Rule of Optimism, where professionals wrongly assume positive outcomes for children, is more likely to exist when staff feel under pressure and this can be very dangerous for children who are at risk.

The Rule of Optimism rationalises evidence that contradicts progress - so even where the facts show that risk is on-going or increasing, professionals tell themselves that the opposite is true.

**Professional Involvement is NOT the Same as Engagement**

Just because another professional is involved with a child's case does not mean that they are proactively engaged with protecting the child.
The danger is that we assume that if a child has a social worker, they are being protected; or if a police officer visited the house after a domestic violence incident, the child is safe. The social worker may not know what you know; the police officer may not have had any cause for concern.

Never assume that someone else is doing something when you have a cause for concern.

Questions to consider:

- Even once you communicate your concern to other workers, how sure are you that you are understood?
- What actions are they taking?
- How do you know?

Disguised compliance happens when parents or carers don’t admit their lack of commitment to the process and work subversively to undermine it.

When carrying out child protection work with black and minority ethnic or faith communities, social workers should not over focus or ignore a family’s culture or faith and maintain a focus on the needs of the child.

It is possible to be culturally sensitive without becoming paralysed and overriding the protection of children.

Want to know more?

NSPCC Factsheet
Messages from children to Adult Mental health Workers:
(with thanks to young people from a Barnardo's project in Liverpool)

1. Introduce yourself. Tell us who you are and what your job is

2. Give us as much information as you can

3. Tell us what is wrong with our parents

4. Tell us what is going to happen next

5. Talk to us and listen to us. Remember it is not hard to speak to us; we are not aliens

6. Ask us what we know and what we think. We live with our parents; we know how they have been behaving

7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame

8. Please don’t ignore us. Remember we are part of the family and we live there too

9. Keep on talking to us and keep us informed. We need to know what is happening

10. Tell us if there is anyone we can talk to. MAYBE IT COULD BE YOU
Resilience is the ability to steer through serious life challenges and find ways to bounce back and to thrive.

We are born with the capacity for resilience. But resilience is not something we have or don’t have. We work on it throughout our lives. And we need to start as early as possible. Parents are the most important people to help build their children’s resilience.

Children learn a lot by watching their parents. When parents cope well with everyday stress, they are showing their children how to do the same.
For many children living with, parental mental illness, disability or drug and alcohol misuse, coupled with other risk factors, such as Domestic Violence, can compromise their ability to remain resilient.

For adult mental health professionals it is important to recognise the needs of the child. Discuss with the adult the needs of the child and capture them in the plan, which should include:

- The impact of the plan on the child
- The impact on prescribed medication on their ability to parent
- The impact of therapy on their impact to parent
- Who could care for the child in the event of their parent not being able to do so?
- What is the support of the wider family?
- Providing the child with information about their parent is a way they can understand
- Parental agreement to keep the school informed?

Want to find out more?

Building resilience in Young Children

What works building resilience?
http://www.barnardos.org.uk/what_works_in_building_resilience__-__summary_1__pdf
Young Carers

Children and young people looking after a parent with mental health issues may be facing additional safety issues, emotional stress and isolation as well as the usual challenges of being a young carer.

Some people fear that they will be stigmatised because of their mental health problems or mental illness, and are therefore reluctant for other people to know. This can lead to a lack of support, and isolation.

Others face direct or indirect discrimination, harassment or bullying within their local communities, which can also lead to isolation, fear or a feeling of being unsafe.

Children and young people who are looking after a parent with mental health issues can also face bullying and can be reluctant to identify themselves as young carers in fear that this will happen.

Sometimes, as well as looking after the parent they are also looking after their siblings and the home becomes somewhere that they are uncomfortable inviting friends to.
You can do thing to help like:

- be aware of the signs to identifying children and young people who are carers;
- consider how you can engage them about their parents care plan (they are ‘experts by experience’) make sure that there is someone there if they need someone to talk to- family, friends or a professional;
- provide information and signpost them to young carers groups;
- share information confidentially with the school, GP or other professionals working with the family so everyone is aware of the issues that a particular young carer is facing;
- listen to them;
- be aware.

“When my Dad is in the hospital there is a ‘special’ room where we can play together, it even has an X-Box and sometimes we take pizza with us for tea”

Young carer

“Being able to spend time with friends to go on trips and play knowing my mum was OK made be happy”

Young carer
Think Family in Supervision

Capturing the voice and experience of the child in supervision

Safeguarding supervision must ensure that the focus of the work is on the child and that the child’s needs are always paramount. There needs to be evidence that the voice of the child is considered and recorded as part of the safeguarding supervisory process.
 Supervision Principles

**Principle 1**  
Staff who regularly work with adults 'at risk' and/or adults who parent/care for children should have formal and regular safeguarding supervision from the outset of their employment.

**Principle 2**  
Supervision is arranged and conducted in such a way as to permit proper reflection and discussion.

**Principle 3**  
All supervisory relationships are subject to formal written agreement between the supervisor and supervisee which includes the plan and purpose.

**Principle 4**  
All supervision sessions should be recorded promptly, competently and stored securely.

**Principle 5**  
Supervisors and supervisees are trained to carry out their role.

**Principle 6**  
The supervisor ensures that the continuing professional development within safeguarding is identified.

**Principle 7**  
Supervision will demonstrate a challenge of assumption and fixed thinking while promoting equality and diversity.
An enquiry should be made to the MASH when you have safeguarding concerns that may require children’s’ social care involvement.

**Before making an enquiry**

Before making a MASH enquiry you need to consider if the child or young person’s needs can be met by other professionals already involved with the family.

It is sometimes difficult to decide the appropriate point of intervention. The Threshold Tool will help you to determine levels of need when making your assessment.

If you are a professional, before making the enquiry you should always inform the parent of your concerns and that you will be making a MASH enquiry and whenever possible seek their consent, except where a child is considered to be at risk of harm and you believe that seeking parental consent may increase this risk.

**When to make an enquiry**

Enquiries should be made when your assessment has identified needs for the child which can only be met through specialist services at Level 3 – acute. In some cases, multiple identified needs under Level 2 – complex (using the threshold matrices) will need specialist services.

You can talk about this with social care practice managers based in the MASH and any decision reached should be clearly recorded by the agencies involved.
How to make an enquiry

Complete the multi-agency enquiry form in as much detail as possible. The information you provide will support threshold decisions and contribute to a single assessment if this has not been done already.

Information should include:

- Name, date of birth, address of the child or vulnerable adult, family members and other household members (with their relationship to the child or vulnerable adult)

- If concerns are about a child - who has parental responsibility?

- Details of the concern

- Description of any injuries

- Notes you have made of what the child/vulnerable adult said

- Name, Date of Birth, address of the alleged abuser/perpetrator if known

Urgent enquiries

If you believe that urgent action is needed because, for example, a child is in immediate danger or needs accommodation, phone:

**Devon** MASH on **0345 155 1071**

**Torbay** MASH on **01803 208100**

Give as much information as you can. Your information will be passed immediately to a manager who will decide the action needed and will normally respond to you within one hour. You must follow up your telephone call by sending a completed referral form to the MASH within 48 hours.
After you have raised an enquiry about a child

If you have made a referral you should provide the parents with a copy of the MASH factsheet which can be found on the relevant Council website. Parents should always be given this information when an enquiry has been made unless it’s a serious child protection concern and doing so would put the child at risk.

Ensure that all concerns, reasons for action or no action, responsibility for action, and any disagreements about action/no actions, are recorded in the electronic record.

If you are unsure about thresholds or seeking consent please seek advice from your line manager.

Make sure you can debrief or talk about the incident with an appropriate individual such as:

- Line Manager
- Named Safeguarding Nurse
- Named Safeguarding Doctor
- Professionals within the service with lead safeguarding role

Want to find out more?

Devon MASH
http://www.devon.gov.uk/mash.htm
Parent Factsheet

Torbay MASH
http://www.torbay.gov.uk/safeguardinghub
Torbay Information and guidance
http://www.torbay.gov.uk/hubformguidance.doc
Attending Meetings

Where Children’s Services and mental health services are jointly involved in providing services for a family or carrying out a joint assessment of parents, the relevant worker from each service should be invited to attend any planning meeting or review held by the other service.

If you are invited to a child protection case conference, but are unable to attend, you must provide a written report to the conference/meeting outlining the work the Trust has undertaken with the parent and providing an opinion on the risk to the child posed by the parent’s mental illness.

If the parent does not agree to the Children’s Services social worker being invited to their Care Programme Approach meeting, the care co-ordinator will discuss with the adult their objections and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the children’s social worker or another children’s worker to attend part of the meeting however, in all situations relevant key information will be provided to the Children’s Services social worker.

Both services need to share information in order to monitor parent’s progress and provide information required for joint assessments. Written documentation, assessments and minutes of meetings must be sent to all professionals involved and put on the respective case files.

Devon Conference / review Report format
**THINK FAMILY – Levels of Risk in Parental Mental illness**

**Risk of significant harm** – if any of the following factors are present they are highly likely to have a direct impact on the safety and well-being of the child and the child will need to be supported by Children’s Social Care and have a plan in place to protect them under section 47 (Child Protection) or section 17 (Child in Need), Children Act, 1989:

- Delusional beliefs/ideas involving the child
- Risk that child will be harmed as part of suicide plan
- The child is the target for parental aggression or rejection
- Co-existing domestic abuse, drug or alcohol abuse
- There is no other adult that can be depended upon to meet the needs of the child
- Multiple adults with mental health drug or alcohol use visit the household
- The parental mental health disorder is designated ‘untreatable’ within timescales compatible with the child’s best interest
- The child is a young carer – caring for the parent.

**Moderate risk of harm** – where, for example, factors such as the following are present, although not of the severity of the above they can potentially impact on parenting and result in concern for the child’s care. The child may require support from children’s social care under section 17, Children Act, 1989 as a child in need or a CAF/DAF within Early Help:

- The presenting mental ill-health (including the effect of medication/treatment) is impacting on the parents’ capacity to consistently meet the needs of the child
- The parent has had previous mental ill-health which has been treated in primary services
- Parental mental ill-health increases at the same time as other changes in the family, for example, separation of adults, bereavement
- New partner joining the household who has not been assessed

**Low risk of harm** – where, for example, factors such as the following are present they require an assessment of the child’s needs to influence planning of the child’s care as part of a CAF/DAF within Early Help:

- Parental learning disability rendering the child more vulnerable
- Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness and impact on the child
- The child is vulnerable due to age, illness, disability or behavioural/emotional issues
- Changes in the child’s behaviour since the onset of the parent’s mental ill-health

**Not considered at risk** – No obvious impact on the child’s health and well-being are evident. Liaise with key professionals (Health Visitor, School or GP) where appropriate and consent to do so is obtained. As events may change the adult mental health professional should keep levels of risk under review and take action where appropriate.

**Examples of protective factors** – when assessing risk to professional will need to consider what protective factors are in place to inform their decision making and next steps, protective factors include:

- There is another adult that can be depended upon to meet the needs of the child
- The adult has insight into their problems, can take action to significantly reduce the impact of their behaviour on the child
- The adult is sufficiently supported and engaged with professionals
THINK FAMILY – Levels of Risk is drug and Alcohol Dependency

Risk of significant harm – if any of the following factors are present they are highly likely to have a direct impact on the safety and well-being of the child and the child will need to be supported by Children’s Social Care and have a plan in place to protect them under section 47 (Child Protection) or section 17 (Child in Need), Children Act, 1989:

- Drug taking causing delusional beliefs/ideas involving the child
- Risk that child will be harmed as part of suicide plan
- The child is the target for parental aggression or rejection
- Co-existing domestic abuse
- There is no other adult that can be depended upon to meet the needs of the child
- Multiple adults who are drug or alcohol dependent visiting the household
- Poor parental management of drug paraphernalia
- Single carer for child
- The child is a young carer – caring for the parent

Moderate risk of harm – where, for example, factors such as the following are present, although not of the severity of the above they can potentially impact on parenting and result in concern for the child’s care. The child may require support from children’s social care under section 17, Children Act, 1989 as a child in need or a CAF/DAF within Early Help:

- The presenting drug and / or alcohol dependency (including the effect of medication/treatment) is impacting on the parents’ capacity to consistently meet the needs of the child
- The parent has previously participated in detox / withdrawal programmes and is not designated ‘untreatable’, wither totally or within timescales compatible with the child’s best interest

Low risk of harm – where, for example, factors such as the following are present they require an assessment of the child’s needs to influence planning of the child’s care as part of a CAF/DAF within Early Help:

- Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into dependency and impact on the child
- The child is vulnerable due to age, illness, disability or behavioural/emotional issues
- Changes in the child’s behaviour since the onset of the parent’s dependency

Not considered at risk – No obvious impact on the child’s health and well-being are evident. Liaise with key professionals (Health Visitor, School or GP) where appropriate and consent to do so is obtained. As events may change the adult mental health professional should keep levels of risk under review and take action where appropriate.

Examples of protective factors – when assessing risk to professional will need to consider what protective factors are in place to inform their decision making and next steps, protective factors include:

- There is another adult that can be depended upon to meet the needs of the child
- The adult has insight into their problems, can take action to significantly reduce the impact of their behaviour on the child
- The adult is sufficiently supported and engaged with professionals
Basic Care, ensuring safety and protection
- Is the home warm enough?
- Is the kitchen / bathroom functional?
- Are there facilities to wash and dry clothes, bedding and towels?
- Is the child’s bedroom age appropriate with bedding and furniture?
- Does the child have enough clothes – including outdoor clothing?
- Is there anything in the home you have seen that makes you feel unsafe?
- Is the accommodation multiple-occupation?
- Is the home in good repair and safe for the age of the child?
- Is there a local children’s centre, health centre and dentist?
- Is drug paraphernalia appropriately stored?

Emotional warmth and stability
- Does the family move home frequently?
- Does the parent have multiple partners?
- Are there frequent visitors to the home?
- Who cares for the child when the parent is not able?
- Does the parent have a regular and reliable friendship network that the child experiences?
- Does the child have regular and reliable contact with any absent parent?
- Does the child have regular and contact with wider family members? If you were upset or frightened who would look after you, and make sure you were all right?
- Have you seen the parent cuddle / provide comfort to the child?
- Have you seen them shout or ignore the child?

Guidance, boundaries and stimulation
- Does the parent provide appropriate time to interact with the child?
- Is the child given appropriate discipline and guidance?
- Have you seen age appropriate toys, books and games for the child?
- Does the parent play with the child?
- Does the child have opportunities to play/interact with other children?
- Do school age children attend regularly and on time?
- Does the child respond to no?
Capacity of the parent/carer to effect the necessary change

- Does the parent have insight into self, child and the circumstances?
- Is there a shared understanding of professional concern/s by the adult?
- Is there a shared understanding of professional concern/s by the wider family?
- What is the parents/carers understanding of the need for change – is change possible?
- Do they sincerely want to change?
- Are they able and willing to work with services to effect change?
- Do we have the resources to help address needs/risk(s) and to build child and family resiliencies?
- How long is it likely to take to effect change?
- Can they change within the timescales to meet the best interest of the child?
- Can they maintain the change required

Protective factors

- Parents who can recognise the when they are mentally unwell and seek help
- Parents who can prioritize the needs of the child before their own substance misuse issues
- Secure storage of drugs
- A non-substance misusing partner or relative who can offer support or provide practical input
- A partner or relative that is mentally well
- Engaged in a drug treatment programme
- Sufficient income / funds
- Provide nursery/day care for the child
- Regular school attendance/supportive teachers
- Supportive friends for the child (especially in adolescence)
- Multi-agency working
- Professionals sharing information
THINK FAMILY – Domestic Violence Prompts

After the issue has initially been raised, you may find the following questions useful when dealing with victims of domestic violence. You can adapt the questions in a way that feels more natural to you and ask them in any appropriate order, and change gender as required. If you have any concerns about how to respond to a disclosure you must discuss the issues with your line manager, lead clinician or other relevant professional regarding the need to share information. These questions will assist you to undertake a risk assessment.

Client focused questions
☐ Do you get support at home?
☐ I noticed a number of bruises/cuts/scratches/burn marks, how did they happen?
☐ Do you ever/did you ever feel frightened/intimidated by your partner?
☐ Does/did you partner ever treat you badly, such as shout at you, constantly call you names, put you down, push you around or threaten you?
☐ Have you ever been in a relationship where you have been hit, punched, hurt in any way? Is that happening now?
☐ Many patients/clients tell me that their partners are cruel, sometimes emotionally and sometimes physically hurting them – is that happening to you?
☐ How are decisions reached?
☐ We all have rows at home occasionally. What happens when you and your partner fight or disagree?

Has your partner ever:
☐ Thrown things?
☐ Destroyed things you care about?
☐ Threatened or abused your children?
☐ Forced sex on you/made you have sex in a way you are unhappy with?
☐ Withheld sex/rejected you sexually in a punishing way?
☐ Used your personal fears to ‘torture’ you?
☐ stalked you?
☐ Does your partner get jealous of seeing friends, talking to other people, going out? If so, how does he then act?
☐ Does your partner / you mention your partner / used drugs / alcohol. How did /does he behave when this happens?
☐ Your partner seems very concerned and anxious – that can mean he feels guilty. Was he responsible for your injuries?

Questions about the household
Be aware that there may be children or adults in need of safeguarding in the household or there may be animals at risk from the perpetrator. You will need to refer to the appropriate polices for adults or children in need of safeguarding. Concerns about animals should be reported to the RSPCA or the police.

☐ What do/did your children do when (any of the above) happens/happened?
☐ How do/did your children feel when (any of the above) happens/happened?
☐ Is there anyone else in the household who might be worried about what is happening?
THINK FAMILY – Supervision Prompts

☐ Understand the primary adult issue which is impacting on their parenting capacity

Is there additional issues?
☐ Mental illness
☐ Drug abuse
☐ Alcohol dependency
☐ Domestic Violence
☐ Learning Disability
☐ Family history of abuse
☐ Parent was in the care system as a child
☐ Parent has experienced abuse as a child
☐ Young parent

The voice of the child
☐ Has the child been spoken to by the adult mental health worker?
☐ Is there any other adult who could talk to the child direct?

Your concerns about the child
☐ Neglect
☐ Poor attachment
☐ Failure to thrive
☐ No emotional warmth
☐ Child not attending school
☐ Child looks uncared for / unhappy
☐ Child has bruises
☐ Age of child
☐ Is the child subject to child protection plan?
☐ Has the child been subject to previous child protection plans?
☐ Does the child have a current social worker?
☐ Is the child is subject to a DAF/CAF?

Level of risk - What action needs to be taken?
☐ Referral to Devon or Torbay MASH (if not known to children’s services)
☐ Contact child’s social worker to share concerns – possible joint visit
☐ Contact school / Health Visitor/ GP to share information
☐ Re-visit /contact adult to share concerns
☐ Review plan for the adult to include actions about the child
☐ Signpost the family to appropriate resources