Cambridgeshire and Peterborough NHS
NHS Foundation Trust

Version 5.0 – February 2012
Due for review July 2013

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

Guidance for Effective Joint Working

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August 2011

For CPFT purposes

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Sponsor	Director of Nursing and Quality
Responsible committee	Patient Safety and Risk Management Subcommittee
Ratified by	Quality and Healthcare Governance Committee
Date ratified	
Date issued	
Review date	
Version	5.0
If developed in partnership with another agency, ratification details of the relevant agency	Peterborough and Cambridgeshire LSCBs

Version Control

Version	Date	Author	Comments
1.0	September 2002	Endorsed by Peterborough and Cambridgeshire Area Child Protection Committees	Development of document
2.0	March 2007	Reviewed by Helen Chrystal and Tracey Collins	Reviewed and updated
3.0	March 2008	Maureen Phillips, Elaine Petch, Tim Bryson	Reviewed and updated
4.0	July 2011	Ben Brown	Planned revision of document. Amendments include: Updated to reflect new Working Together 2010 and a local serious case review (Child F). More information added to guide risk assessment and management, keeping a child focus, getting help for adults with mental health problems, peri-natal mental health, and communicating effectively about mental health problems.
5.0	February 2012	Judy Jones	Amended 10.3 following recommendations from the PSCB on 24 Nov 2011

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1 Purpose

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

- the impact of parental mental health on parenting
- the impact this may have on children
- the risks to children from parental mental illness
- how to work effectively with other agencies to help families and safeguard children

2 Background

2.1 Everyone shares the responsibility for safeguarding and promoting the welfare of children. When there are concerns, close collaboration and liaison is required between professionals who have different roles and expertise. This may include staff from adult mental health services, children's social care, schools, health visitors, school nurses and other local authority and voluntary sector workers. When there are child protection concerns it is essential that information is shared at an early stage and effective communication takes place.

2.2 This guidance is informed by national and local guidance and research as well as the findings of two local Serious Case Reviews[1]. These reviews have highlighted the importance of recognising that the onset of parental mental illness can present a risk to children even when there is no previous history or abuse or neglect. When concerns arise it is essential that all professionals involved with the family develop a shared understanding of the parental mental health problem and the specific risks this may pose to the children.

2.3 While many parents with mental health problems and mental illness are able to parent effectively consideration must be given to the impact a parent's condition and symptoms may have on the child and what support the family may need as a whole. This involves working collaboratively with families. Professionals need to engage with parents at the earliest opportunity, as doing so may prevent problems or difficulties becoming worse. When multi-agency plans are developed (including child in need and child protection plans) these must be clear to everyone involved, as well as the family themselves.

> **Remember:** If you think a child or young person is experiencing or likely to experience significant harm then you have a duty to inform Children's Social Care. See key contacts.
>
> It is good practice to discuss your concerns with the parents at this stage unless there is a good reason for not doing so. Research shows that parents will find it easier to work with professionals to ensure the welfare of their child if they are dealt with openly from the outset.

[1] Executive summaries of Family T and Child F serious case reviews are available from
- Family A - Peterborough LSCB – www.peterboroughlscb.org.uk/pro_scr.html
- Child F - Cambridgeshire LSCB – www.cambslscb.org.uk/prof_scr.html
See also 'Learning lessons from serious case reviews 2009-2010'. Ofsted 2010

3 Information sharing

3.1 When shortcomings are identified in agencies attempts to help a family where there are safeguarding concerns, it is often because the right information is either not sought or not shared.

3.2 It is therefore important to gather:

- the child's views
- information from or about fathers, whether living in the home or elsewhere, and other adults living in the home
- contributions from the extended family
- historical knowledge about members of the family
- relevant information from other agencies involved with the family
- the cultural background of the family
- research findings about abuse, neglect, domestic violence and substance misuse, where they were relevant to the particular case

3.3 *Reaching a shared understanding of the parental mental health problem is key.* Does everyone involved with the family understand the nature of the parental health problem and how it may impact on their parenting and the child? See Appendix 4 for guidance about communicating effectively with others about mental health problems.

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

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

3.6 *Often, it is only when information from a number of sources has been shared and pulled together that it becomes clear that there are concerns a child is in need of protection or services.* Promoting young people's well being and safeguarding them from harm therefore crucially depends upon effective information sharing, collaboration and understanding between agencies and professionals.

3.7 Decisions to share information must always be based on professional judgement about the safety and well being of the individual and in accordance with legal, ethical and professional obligations.

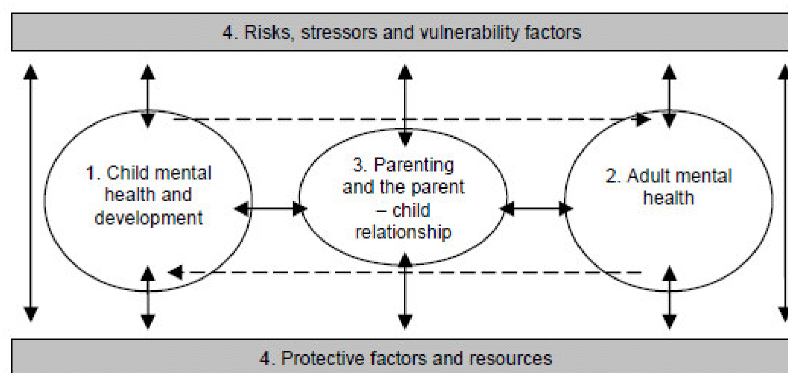
See also Information sharing: Guidance for practitioners and managers. Available at: www.ecm.gov.uk/informationsharing

4 Assessment – Think Child, Think Parent, Think Family[2]

4.1 The mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked. The model below demonstrates that in order to understand the risks to health and well-being, it is important to think beyond the parent's diagnosis.

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

- the cumulative effect of risk factors (e.g. domestic abuse, drug and alcohol use, housing problems, financial problems, discrimination and stigma)
- the presence or lack of protective factors and resources (e.g. family network, isolation, community resources and sources of support)
- life events (e.g. hospital admission, traumatic experiences, child protection conferences, moving house, health problems)
- Individual differences (people with the same diagnosis can experience very different symptoms and behave in different ways. Impairment can change over time)



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

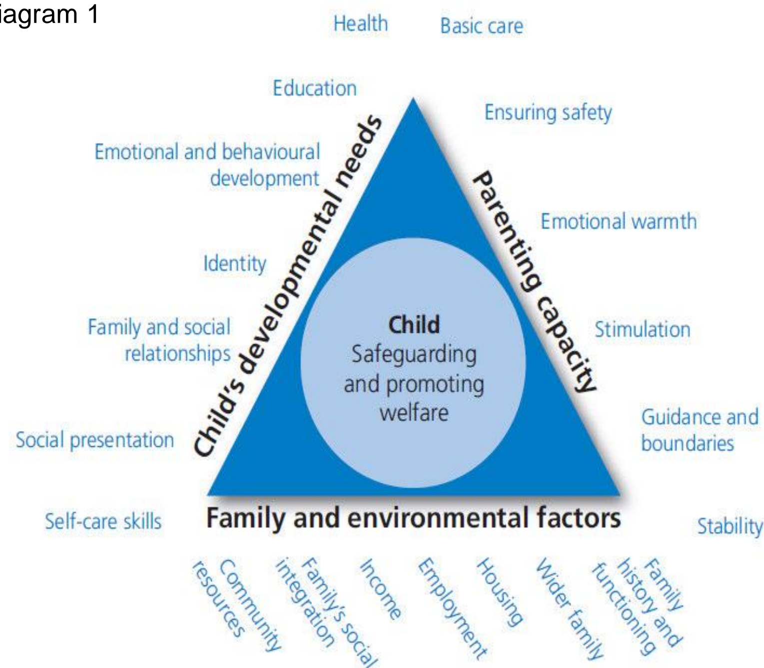
> *"Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process."*
> Scottish Recovery Network 2009

[2] **SCIE** Guide 30: **Think child**, **think parent**, **think** family: a guide to parental mental health and child welfare. Published: July 2009

4.4 The Framework for the Assessment of Children (2000) and (CAF) also provide a useful tool for understanding and describing the impact of parental health problems on parenting and child development. See Diagram 1 below and Appendix 1 for examples.

4.5 The Common Assessment Framework (CAF) can also be used to assess need and access support for children and young people in Cambridgeshire and Peterborough. See Section 9 for more details.

Diagram 1



4.6 A comprehensive assessment should;

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

5 Risk Assessment and Management

5.1 It should not be assumed that all parents with a mental health problem pose a risk to their children. Often a comprehensive assessment, collaborative working and careful planning will help minimise any potential impact on the child.

5.2 There are however situations where children are at risk due to the nature of the parent's mental illness and its impact on their parenting. Appendix 2 provides some guidance to help you consider these risks.

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

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

5.4 Delusional beliefs are an example of 'psychotic' symptom which may occur in some serious mental illnesses. See Appendix 5 for a description of what is meant by 'delusional beliefs' and 'psychosis'.

5.5 All users of mental health services are assessed using the Care Programme Approach (CPA). This includes an analysis of the person's health and social care needs including the presenting problem and a risk assessment. It should also identify any safeguarding children concerns and how these will be managed.

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

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

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

Managing risk

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

- Where parental psychosis is identified, mental health services should clearly outline the specific behaviours that might be evident during a period of illness.

- It is important to understand a patient's 'relapse signature'. For example, if a patient has presented a risk to a child during a previous psychotic episode then this must be considered a potential risk during a future relapse e.g. actual physical harm or threats to harm.

Managing risk

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

- It is important that all agencies involved understand how to recognise the early warning signs of a relapse, the triggers for deterioration and the specific risks to children that may result.
- Mental health staff have an important part to play in communicating risks to other agencies. Non mental health staff should take steps to seek a better understanding if they are unclear.
- Child protection plans in cases of parental mental health should be categorised into two sections: plans for when the parent is well, and plans for periods of ill health.

6 Keeping a child focus

6.1 When there are safeguarding concerns about a family, too often the focus on the child is lost. Adequate steps may not be taken to establish the wishes and feelings of children and young people, and their voice is not sufficiently heard (Ofsted 2010).

6.2 It is important to establish whether the child feels safe as well as ascertaining whether they are subject to a 'child in need', 'child protection plan' or other legal order.

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

- Children often worry hospital will make their parents worse
- Children can worry that they might “catch” their parent’s mental health problem
- They may want to visit the parents in hospital
- They may feel responsible for making their parents feel better
- They may have their own way of telling when their parent is becoming ill
- Many children feel isolated and that they cannot join in with others of their own age
- Academic success does not mean a child or young person is coping
- Some young people may feel they have gained some benefit from their experience of their parents mental illness
- Often no one explains anything to children or young person
- Children may not want formal counselling but may need someone to talk to
- (Falkov 1998)

6.4 A range of resources are available to help children and young people understand mental health problems and facilitate a discussion about their experiences. See references and resources page.

6.5 Appendix 3 has some tips for working with children and families.

7 Getting Help for Parents with Mental Health Problems

7.1 Accessing Help

The best source of information about the services provided by Cambridgeshire and Peterborough NHS Foundation Trust is the CLINICOM website.

www.clinicom.cpft.nhs

Referrals to adult mental services can be made via GPs. Advice is also available from gateway workers who are based geographically and are linked to specific GP surgeries. Contact details are listed on the CLINICOM website. It also includes details about psychiatrists and care pathways.

7.2 Help in a crisis

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

During normal office hours please call your local Community Mental Health Team. For adults not known to CPFT mental health services and their carers, it is advised that a first point of contact should be the local on-call GP service, which will be able to undertake an initial assessment of their needs and be able to review their care records. This is especially important as they may have physical health needs affecting their mental health.

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

A number of voluntary organisations also provide help to adults with mental health problems, including MIND, the Richmond Fellowship and Sane. Links to this and more are available from www.cpft.nhs.uk. Follow 'Patients & carers' and 'Useful links' tabs.

Other Telephone Help for Adults

Lifeline - 0808 808 2121. Providing a freephone confidential support service across Cambridgeshire between 7.00pm and 11.00pm, 365 days a year.
Samaritans - 08457 90 90 90
Sane - 0845 767 8000
NHS Direct - 0845 46 47

As well as help for their mental health problem, here are some things that parents say they want for themselves.

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

8 Managing hospital admissions

8.1 A parent going into hospital, especially at short notice can be a very stressful time for all family members. Everyday routines are disrupted, other adults are often overstretched, and both parents and children can feel worried and powerless. Those agencies involved with the family must consider the needs of the children whilst the parent is in hospital and ensure that sufficient arrangements are in place to keep them safe.

8.2 Disruption will be minimised and safeguarding will be most effective if the ward staff and other mental health professionals liaise effectively with other agencies involved with the family so together they can form part of an overall plan to manage the admission.

8.3 In all cases the ward staff must consider involving these agencies in discharging planning and give adequate notice of discharge and leave arrangements. For example, any parent with a child under 5 yrs old will have a health visitor assigned to them. Children subject to 'child in need' or 'child protection plans' will have an allocated social worker.

8.4 When appropriate, the parent's CPA care plan should include a clear contingency or crisis plan detailing how a future admission will be managed. This should include how many children the parent has, their ages and gender, and the arrangements for their care whilst the parent is in hospital. It must be written with the parent and shared with other relevant members of the family, including children if they are old enough.

8.5 Children should be given the opportunity to visit their parent in hospital. Planning for these visits should take account of their views and wishes. The child's best interests must come first however and a risk assessment must be undertaken by the ward team to determine whether it is appropriate for the visit to take place. When a child visiting is appropriate and safe, it should be handled in a non bureaucratic and supportive manner, which does not cause delay and which maximises the benefits of the contact for both the child and the adult.

See Appendix 6 for a checklist of things to consider when managing a hospital admission.

9 Peri-natal mental health

9.1 Key Facts

- The peri-natal period includes pregnancy and the year following birth.
- Mental health problems during this period affects one in six women.
- Women are more likely to develop a mental health problem during the peri-natal period than any other time in their lives. They are also at greater risk of a relapse during this time if they have a history of mental health problems.
- Some women will experience relatively mild distress during pregnancy or after birth whilst some may develop severe depression and a few will experience psychosis.
- Inquiries have shown that suicide is one of the leading causes of maternal death in the UK, so early detection, prevention and treatment of problems in peri-natal period is crucial.
- Peri-natal illnesses can have a negative impact on the baby. For example, babies of anxious mothers may be born with abnormal stress responses. A child in its first year may not be able to form a secure attachment if its mother has been depressed. This can have long term consequences for development.

Women can experience the whole range of mental health problems during pregnancy and the postnatal period. However they can be categorised as follows,

1) Antenatal depression
2) Postnatal depression
3) Puerperal psychosis and
4) Pre-existing conditions including, anxiety disorders, bi-polar disorder and major depression

9.2 Antenatal Depression

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

For women suffering with antenatal depression establishing links between mental health services, the midwife, the GP and the health visitor should be routine. Advice is also available from the Peri-natal nurse specialists and Named Midwifes for Safeguarding and Vulnerable Women. See Key Contacts.

9.3 Postnatal Depression

Depression in the postnatal period is the most common mental health problem for women in the period following childbirth. Women who are socially isolated and single parents may be particularly vulnerable. Women experience general symptoms such as lowered mood, sleep disturbance and lack of pleasure, but alongside this may be increased worry about their baby and a loss of enjoyment

and joy in motherhood.

These women will benefit from support from health visitor, GP, local groups and accessing mental health treatment, including talking therapies.

It is vital that women do not abruptly stop their prescribed medication during the peri-natal period. Advice should be sought from their doctor.

9.4 Puerperal psychosis

This is a relatively rare but serious and acute illness (1-2 in every 1000 births) often occurring in the first few days and weeks following child birth. Many women will have no previous history of mental illness but some may have been diagnosed with a bi polar illness or have a family history of mental illness.

Women presenting with early signs may be profoundly distressed and disturbed and experience fear and perplexity, hallucinations and delusions, restlessness and agitation and/or feelings of elation or deep depression.

Due to the severity of the illness it is likely that the mother's parenting capacity will be affected during the time of illness, in some cases presenting a significant risk to the baby. The needs of the child and family, (including contact with the child) will need to be carefully and sensitively considered and any safeguarding concerns addressed. See Section 5 for more about the risks associated with a psychotic episode.

A significant number of women with a puerperal psychosis will go on to be diagnosed with a bi polar illness and the treatment is the same. For women with puerperal psychosis admission to hospital is likely (often to a mother and baby unit) and drug treatment is important. Recovery rates are good and women respond well to appropriate care.

Due to the severity of the illness it is likely that the mother's parenting capacity will be affected during the time of illness. The needs of the child and family, (including contact with the child) will need to be carefully and sensitively considered and any safeguarding concerns addressed. See Section 5 for more about the risks associated with a psychotic episode.

See Appendix 5 for a description of what is meant by 'puerperal psychosis'.

9.5 Pre-existing conditions

Some women with pre-existing conditions such as anxiety disorders (including obsessive compulsive disorder and panic disorder), severe depression, or psychotic illness may relapse during pregnancy and the postnatal period. They are at higher risk of relapse if stopping medication.

Women with a history of bi-polar affective disorder, puerperal psychosis or a family history of puerperal psychosis are at particularly high risk of relapse. This is most common in the first few weeks after the birth with most occurring within the first month.

For women with a history of puerperal psychosis, subsequent episodes are likely to occur at a similar interval after the birth than the previous occasion. Symptoms are often extreme, fluctuating and of rapid onset (within 48hrs). The nature and severity of some symptoms may limit the capacity of the mother to adequately care for her baby. The needs of the child and family will need to be carefully considered and any safeguarding concerns addressed.

9.6 Medication, Preconceptual, Antenatal and Postnatal Care

Women who are planning to start a family and are taking psychiatric medication should discuss this with their GP and/or psychiatrist if under the care of psychiatric services. They will need advice and information about relative benefits and risks of taking medication in pregnancy and breastfeeding.

Women at risk of a recurrence of illness should discuss this with their doctor in order to identify any necessary measures to reduce risk of relapse. If medication is necessary the risk should be minimised by using the lowest effective dose for the shortest time. Ideally the first 12 weeks of pregnancy medication should be avoided if possible. Doctors prescribing medication should access up to date information and seek specialist advice as appropriate.

> Women with a mental illness are more likely to deliver prematurely. A pre-birth planning meeting should therefore be held before 35 weeks gestation.

9.7 Sources of advice

There are a number of professionals providing specialist help to women and their families during the antenatal and post natal period. These include specialist midwifes, peri-natal mental health nurses and a specialist consultant psychiatrist. See key contacts.

9.8 Other Sources of Information

NICE has published guidance for all health agencies and staff concerned with the care and treatment of mothers with mental disorder during pregnancy and in the postnatal period. The guidance covers all mental health problems and gives advice about the detection, assessment and treatment of antenatal and postnatal mental health problems.

See Ante-natal and post-natal mental health: NICE Guideline. National Institute of Health and Clinical Excellence 2007.

10 Acting on Concerns about Children

10.1 There will be circumstances where you do not think the child is at risk of significant harm but feel that their health or development may be at risk if they do not receive additional help from one or more services. Interagency work should start as soon as there are concerns about a child’s welfare, not just when there is a ‘child protection’ concern.

10.2 The Common Assessment Framework (CAF) provides a good framework for assessing the needs of children and should be used to co-ordinate help for the

child and family. If you are unsure how to sue the CAF contact your locality team or CAF co-ordinators.

See: www.cambridgeshire.gov.uk or www.www.peterborough.gov.uk

CAF **SEARCH**

10.3 Children in need

If multi-agency work with the child and family is judged not to be improving, the agreed outcomes for the child or young person a referral can be made to Children's Social Care who have a duty to undertake an initial assessment in relation to providing additional local authority services. You can make referrals to social care for 'children in need' in the same way you would for 'children in need of protection' (i.e. a telephone referral followed up with a written referral). If an initial assessment is undertaken this may result in the child being made subject to a 'child in need' plan under Sec 17 of the Children Act 1989.

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

10.4 Children in Need of Protection

If you think a child may be suffering or at risk of suffering significant harm, you must refer the child to Children's Social Care or the Police. Unless the child is at immediate risk of harm a referral to social care is likely to be the more appropriate route. A referral can be made by phone (see key contacts). It is good practice to follow up a telephone referral with a written referral. You may be asked to submit a CAF (if one has been completed) or a Statutory Intervention Form (Cambridgeshire).

If you think the child may already be know to Children's Social Care you can ring and ask them to check their records.

Any professional who has had contact with the child or family, however minimal, is expected to contribute to the child protection process including attending child protection conferences and submitting reports.

11 Young Carers

In some circumstances the child/ young person may be providing a caring role for one or more parents. Young carers are not necessarily children in need, but should always have their needs thoroughly assessed; as a carer, they should have the same rights as other carers as outlined in Standard 6 of the National Service Framework. All carers, including young carers, should be advised of the carers register and any available information and resources.

Sources of information/ support include:
http://www.peterborough.gov.uk/peteyouth/life   living/young_carers.aspx
http://www.cambridgeshire.gov.uk/social/carers/youngcarers/carerycsw.htm

12 Professional Disagreements and Escalation

12.1 It is important that there is respectful and constructive challenge whenever a professional or agency has a concern about the action or inaction of another. Similarly, professionals should not be defensive if challenged, and always prepared to review decisions and plans with an open mind.

12.2 Professional disagreement is only dysfunctional if not resolved in a constructive and timely fashion. Common disagreements can arise as a result of differing view of service thresholds, lack of understanding of roles and responsibilities, or the need for action and communication.

12.3 The aim should be to resolve difficulties at practitioner/fieldworker level between agencies if necessary with the involvement of their supervisors or managers, engaging in open discussion with colleagues in other agencies. At no time must professional disagreement detract from ensuring the child is safeguarded. The child's welfare and safety must remain paramount throughout.

12.4 Both Cambridgeshire and Peterborough LSCBs have an Escalation Policy you can follow. See key contacts.

13 Working with Children and Parents who are Difficult to Engage

13.1 Cambridgeshire LSCB has produced a useful guide that draws upon the available research in this area. It is available from: www.cambslscb.org.uk/prof-pub.html

13.2 Further guidance is also available within the LSCB Core-interagency Procedures for working with hostile, non compliant clients and those who use disguised compliance within the context of safeguarding children.

APPENDIX 1

USING THE FRAMEWORK FOR THE ASSESSMENT OF CHILDREN

Mental illness in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family.

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

Children’s Developmental Needs

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

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

Parenting Capacity

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

Family and environmental factors

- Is there another parent/carer who can provide compensatory care when

needed?

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

APPENDIX 2

PARENTAL MENTAL ILLNESS AND SAFEGUARDING CHILDREN UNDERSTANDING THE RISKS

Many parents with mental health problems and mental illness are able to parent effectively. Nevertheless consideration must be given to the impact a parent's condition and symptoms may have on the child and what support he family may need as a whole.

Some parents with a severe mental illness do present a risk to their children and where it is thought the child has experienced or is likely to experience significant harm the duty of care that a health professional owes to a child will take precedence over any obligation to the parent or other adult.

Risks should also be considered for service users who are not parents but are in contact with children – e.g. service users with younger siblings or grandchildren.

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

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

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

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

Several local serious case reviews have highlighted the importance of understanding a patient's 'relapse signature'. For example, if a patient has presented a risk to a child during a previous psychotic episode then this must be considered a potential risk during a future relapse.

It is important that all agencies involved understand how to recognise the early warning signs of a relapse and the specific risks to children that may result. Mental health staff have an important part to play in communicating these risks to other agencies. Non mental health staff should take steps to seek a better understanding if they are unclear.

There are particular risks associated with the ante-natal and post-natal period. See Sec 7 and NICE Guidance CG456.

APPENDIX 3

TIPS FOR WORKING WITH CHILDREN AND FAMILIES

A group of young carers in Merseyside (Barnardo's 2007) came up with following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems.

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

APPENDIX 4

COMMUNICATING EFFECTIVELY ABOUT PARENTAL MENTAL HEALTH PROBLEMS

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

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

Information should be shared when it is necessary and relevant. Discuss with the parent what you intend to share unless there is a good reason for not doing so.

The following questions will help mental health professionals and non mental health professionals consider what information might be useful to share or seek when communicating about parental mental health problems.

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

APPENDIX 5

WHAT IS PSYCHOSIS AND PUERPERAL PSYCHOSIS?

Psychosis is a condition that affects a person's mind and causes changes to the way that they think, feel and behave. A person who experiences psychosis may be unable to distinguish between reality and their imagination.

People who are experiencing psychosis are sometimes referred to as 'psychotic'. They may have:

- **Unusual beliefs called delusions.** These very strong beliefs are obviously untrue to others, but not to the sufferer. For example, thinking there is a plot to harm them, or that they are being spied on by the TV, or have been taken over by aliens. Sometimes, they may feel they have special powers.

- **Thought disorder** is when a person cannot think straight. Ideas may seem jumbled, but it is more than being muddled or confused. Other people will find it very difficult to follow what the person says.

- **Hallucinations** are when the person can see, hear, smell or feel something that isn't really there. The most common hallucination that people have is hearing voices. Hallucinations are very real to the person having them. This can be very frightening and can make the person believe that they are being watched or picked on.

Psychosis is not a condition in itself, it is a symptom of other conditions. The most common cause of psychosis is a mental health condition, such as schizophrenia or bipolar disorder (manic depression).

Psychosis can also be triggered by physical conditions, such as Parkinson's disease, or as a result of drug or alcohol misuse. The length of time that someone will experience a psychotic state of mind, known as a psychotic episode, will depend on the underlying causes. Drug or alcohol-induced psychosis many only last for a few days. However, psychosis that results from schizophrenia or bipolar disorder may last indefinitely unless it is treated.

Puerperal psychosis (also known as postpartum psychosis) is a psychotic episode in the post-natal period, usually within a few days after childbirth. It should be considered a psychiatric emergency.

Source: www.nhs.uk/Conditions/Psychosis/Pages/Introduction.aspx *and*
http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/psychoticillnessyoungpeople.aspx

For more information about psychosis visit www.cameo.nhs.uk.

CAMEO is an NHS service that provides specialised assessment, care and support to young people experiencing a first episode of psychosis in Cambridgeshire and Peterborough.

APPENDIX 6

MANAGING HOSPITAL ADMISSIONS

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

- Are the children safe?

- Has key information about the children been documented during admission? This will enable you to consider their needs whilst the parent/guardian is in hospital and plan discharge effectively. *Including, names, date of birth, school, GP.*

- Who is in the family? Do you have detailed knowledge of who is looking after the children whilst the parent is in hospital?

- Have you communicated with others involved with providing care/support to the parent or others in the family? For example, health visitors, school nurses, GP, mental health services, voluntary sector, Children's Social Care.

- Does the parent's CPA care plan include a contingency/ crisis plan to manage future admissions and has it been shared with other professionals involved with the family?

- Have any financial and housing issues arising from hospitalisation (e.g. interruptions in welfare benefits, assistance with child care to avoid a parent or carer having to take unpaid leave to look after the children during this time) been considered?

- Are the children's school aware of the temporary changes in the family to help ease the path of return when the parent returns home?

- Has anyone explained the admission to the children? Have their views and wishes been taken into account?

- Have the children been offered the opportunity to visit their parent in hospital?

- If a service user is being discharged to another service (e.g. GP, community mental health team) has relevant up-to-date information been shared with the receiving team or service prior to or on the day of discharge? *Including, any information relating to safeguarding children.*

- Has a discharge planning meeting been arranged, with the relevant agencies/professionals invited. Has the outcome of the meeting been communicated properly? *Including updated CPA Care Plan, risk assessment, contingency/ crisis plan detailing any issues related to safeguarding children.*

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

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

APPENDIX 7 - KEY CONTACTS

CPFT
Dr Fiona Blake
Nightingale Court, Cambridge 01223 884488

Beverley Pearson
Peri-natal Nurse Specialist
Newton Centre, Huntingdon 01480 415340

Juli Broder
Peri-natal Nurse Specialist
Agenoria House, Wisbech 01945 482100

Annabelle Wilson
Peri-natal Nurse Specialist
Union House, Cambridge 01223 533300

Other useful contacts
Jo Goddard Named Midwife for
Safeguarding Children / Vulnerable Women
The Rosie Hospital
Cambridge 01223 348988

Vicky Lister
Named Midwife for Safeguarding Children
Hinchingbrooke Hospital
Huntingdon 01480 416445

Helen Foster
Named Midwife for Safeguarding and Lead Midwife for Vulnerable Women
City Care Centre
Peterborough 01733 776181

Lesley Edwards
Advanced Midwife Practitioner
Peterborough
01733 673776

Cambridgeshire Children's Social Care
T 0345 045 5203
(out-of-hours Emergency Duty Team -
01733 234724)
F 01480 376748

Peterborough Children's Social Care
T 01733 864180
(out-of-hours Emergency Duty Team -
01733 561370) F 0870 2384083

Cambridgeshire Local Safeguarding Children Board (LSCB)
http://www.cambslscb.org.uk
Telephone: 01480 373522

Peterborough Local Safeguarding Children Board (LSCB)
http://www.peterboroughlscb.org.uk/contact.html
Telephone: 01733 863475

APPENDIX 8

REFERENCES AND RESOURCES

This guide is supported by the following national policy, law and guidance.

Carers (Equal Opportunities Act 2004)

Children Act 1989, section 17 and section 47

Carers (Recognition and Services) Act 1995

Modernising the Care Programme Approach, Department of Health 1999

National Services Framework ('Standard 6 - Carers') 1999

Framework for Assessing Children & Families in Need, Department of Health 2000

Working Together to Safeguard Children 2010

Children Act 2004

NICE (2007) NICE guidance – 'Antenatal and postnatal mental health'. February 2007

(SCIE 2009) Think child, think parent, think family: a guide to parental mental health and child welfare.

Ofsted (2010) Learning lessons from serious case reviews 2009–2010

Ofsted's evaluation of serious case reviews from 1 April 2009 to 31 March 2010

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

Patients as parents. Addressing the needs, including the safety, of children whose parents have mental illness. Royal College of Psychiatrists, London. Council Report CR105. June 2002

NPSA (2009) Rapid Response Report Preventing harm to children from parents with mental health needs. NPSA/2009/RRR003

Making Time to Talk. Advice for parents with mental illness NSF Scotland http://www.pmhcwn.org.uk/resources.asp

Children of Parents with Mental Illness (www.COPMI.net.au)

MIND http://www.mind.org.uk/Information/Factsheets/

Wishing Wellness: A Workbook for Children of Parents with Mental Illness
– Lisa Anne Clarke

Why Are You So Sad: A Child's Book About Parental Depression (Paperback) – Beth Andrews

Mommy Stayed in Bed This Morning: Helping Children Understand Depression - Mary Wenger Weaver