

Joint working protocol

**Safeguarding children and young people
whose parents / carers have problems with:**
mental health, substance misuse, learning
disability and emotional or psychological
distress

Date: April 2011

Review Date: April 2013



“Safeguarding children is everybody’s business”

(The Lord Laming)

This multi-agency protocol has been written for any staff or volunteers working with people whose complex problems might impact on their ability to care for children and for those working with children whose parents or carers have those complex problems.

It gives information about research and guidance for good practice. Parts 1 and 2 should be read by all; parts 3-5 giving more specific information to be used depending on particular needs within the family.

Although not an exhaustive list, it should be read by staff and volunteers working in or as:

- Adult Services
- A&E Departments
- Ambulance service
- Armed Forces welfare
- CAMHS
- Children’s Centres
- Children’s Services
- Citizens Advice Bureaux
- Counselling Services
- Domestic Abuse Services
- Early years’ settings
- Fire & Rescue services
- GPs
- GP practice nurses
- Health Visitors
- Housing providers
- Housing support providers
- Mental health services
- Midwives
- Police
- Probation
- Prison
- Rape Crisis services
- Refuges
- Schools & Colleges
- Substance misuse services
- Voluntary organisations
- Youth Offending Teams

If your concerns are about immediate neglect or harm to a child, whether emotional, physical or sexual, the Local Safeguarding Children Board child protection procedures should be followed without delay. www.4lscb.org.uk

There is a glossary of terms used at the back of the document

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Joint working protocol: safeguarding children

whose parents/carers have problems with mental health, substance misuse, learning disability and emotional or psychological distress

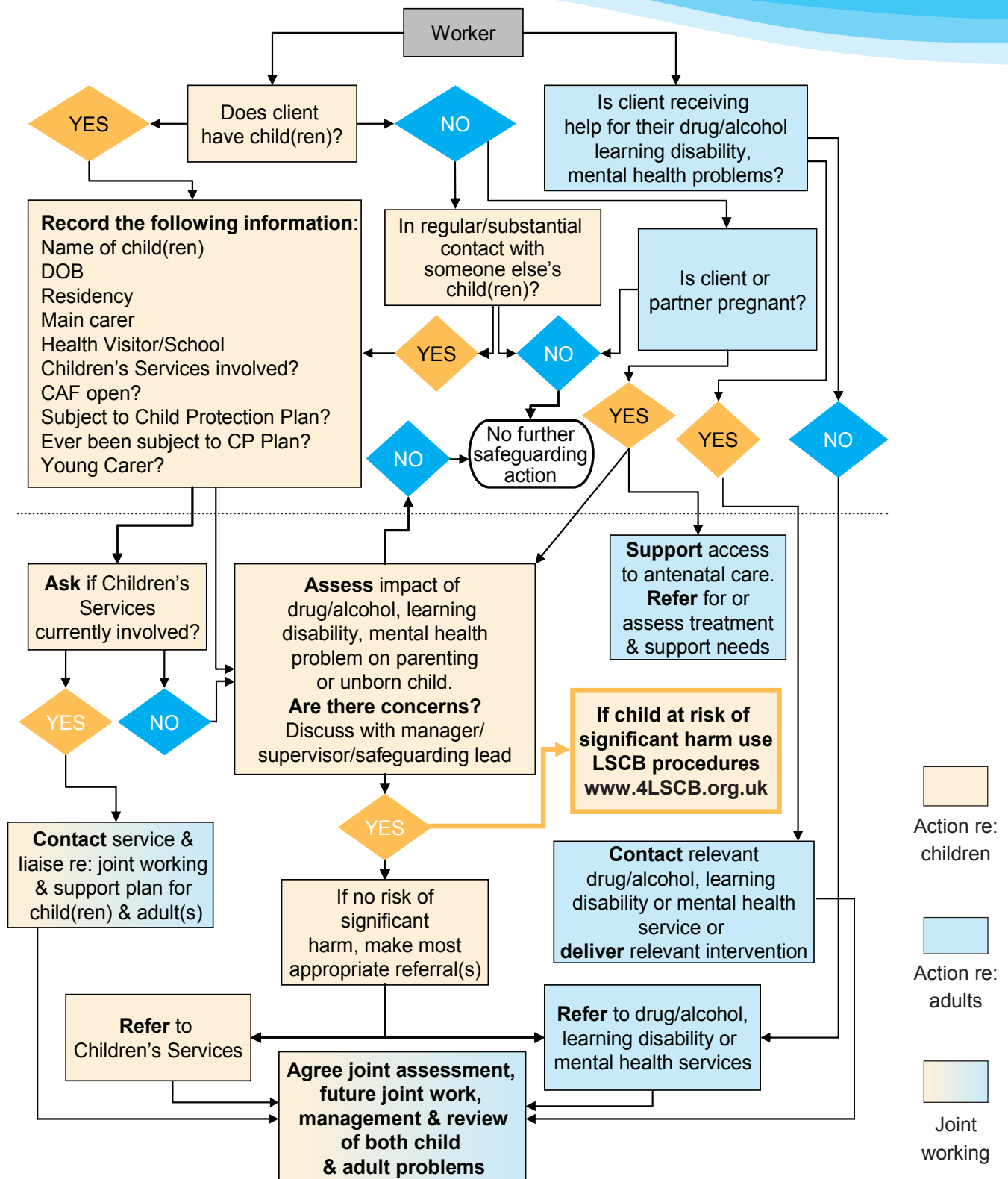
KEY MESSAGES

“Safeguarding children is everybody’s business” (The Lord Laming)

- This protocol has been written for any staff including GPs and volunteers working with people whose complex problems might impact on their ability to care for children and for those working with children whose parents or carers have those complex problems.
- If concerns are about immediate neglect, or harm, whether emotional, physical, or sexual, to the child, the Local Safeguarding Children Board child protection procedures should be followed without delay. www.4lscb.org.uk.
- Practitioners working with adults should identify and record at an early stage:
 - the adult’s relationship with any children
 - parenting responsibilities
 - which other agencies they need to work with if they have concerns about unborn babies, children or young people.
- Practitioners should discuss concerns with the family and seek their agreement to making referrals to services for children and families unless this places a child at increased risk of significant harm. The child’s interest must be the overriding concern in such decisions.
- The data protection law should not be used as a barrier to appropriate information sharing between professionals to protect children or adults from harm.
- A person may not meet the criteria for access to services for adults, but under Fair Access to Care criteria any safeguarding issues escalates eligibility status to critical or substantial.
- Mental health, substance misuse and learning disability problems can increase the risk of harm to children, especially when combined with domestic abuse, or other violent crime.
- If a service user expresses delusional beliefs involving their child and/or they may harm the child as part of a suicide plan, a referral to Children’s Services must be made immediately.

- It is important that if a practitioner feels that a person may be a risk from an **untreated** psychosis they alert the GP in order for the GP to arrange a mental health assessment.
- Other triggers, such as pregnancy, separation, divorce, bereavement, incarceration and discharge from prison, return from active military service, financial difficulties may cause emotional distress and are associated with increased risks to the whole family. Any changes in family circumstances should trigger a re-assessment of risk to children.
- Stereotypes and prejudices which exist about adults who use drugs/alcohol or have mental health or learning disability problems must not influence assessments.
- Supervision, guidance and support from someone with knowledge of safeguarding is essential for people working with adults in contact with children.
- Young carers need to be identified as this can have detrimental effects on young people's education, health and emotional well-being.

Joint working protocol: safeguarding children flowchart



1. Part 1: Introduction

1.1 PURPOSE

- 1.1.1
- To safeguard and promote the welfare of children and young people, including young carers, whose lives are affected by parents/carers using drugs/alcohol or by parents/carers with mental health problems, learning disabilities, or other complex problems e.g. acquired brain injury, progressive neurological condition, that may adversely affect their ability to parent or care;
 - To promote effective communication between adult drugs/alcohol, mental health, learning disability, primary health care, other services and Children's Services (social care);
 - To set out good practice for the services involved to enable working together in the assessment and care planning for families with problematic substance use, mental health, learning disability or other complex problems and to ensure their full participation in the process wherever possible.

N.B.

In the context of this protocol 'parent/carers' includes anyone who has access to the child, for example, members of the extended family and friends or acquaintances.

The term 'children' refers to those aged 0-18 years of age. The needs of unborn babies must also be considered.

1.2 SCOPE

- 1.2.1
- These guidelines have been written for use by the many statutory, non-statutory, voluntary, independent sector and primary care services working with parents/carers who may have mental health, learning disability, drug/alcohol or other complex problems.

It has been written by a multi-agency group with representatives from the many voluntary, statutory and non-statutory agencies that provide services to the residents of any of the 4 LSCB areas (Hampshire, Isle of Wight, Portsmouth and Southampton). It has been informed by consultation that included child and adult service users. The document has been ratified by the 4 LSCBs.

All services represented on the 4 LSCBs will be expected to know of the existence of this protocol and be able to recognise when it should be used.

- 1.2.2 All practitioners are expected to use this protocol when they come into contact with:
- an adult with drug/alcohol, mental health or learning disability issues or other complex problems who is caring for, or has significant contact with, a child
 - a child whose life is affected by a parent/carer's use of drugs/alcohol or who has mental health, learning disability or other complex problems.

N.B.

Practitioners working with adults should identify and record at an early stage the adult's relationship with any children.

- 1.2.3 It is important to note that this protocol is relevant as long as concerns about the parent's capacity to meet the needs of the child/children are at a level where the child is not suffering harm. If the concerns are about immediate neglect, or harm, whether emotional, physical, or sexual, to the child, the Local Safeguarding Children Board child protection procedures must be followed without delay.

www.lscb.org.uk.

- 1.2.4 It sits at a level of secondary prevention in terms of the standard categories of prevention, where a quick response is required to prevent low level problems from getting worse. At times low level signs may be 'the tip of the iceberg' and an early discussion, referral or joint assessment may prevent more serious harm or neglect of a child.

[\(The Munro Review of Child Protection Interim Report: The Child's Journey, Professor Eileen Munro, 2011, page 23\)](#)

<http://www.education.gov.uk/munroreview/downloads/Munrointerimreport.pdf>

- 1.2.5 This protocol applies to unborn babies, children and young people to the age of 18. There is growing evidence that teenagers who are exposed to neglectful parenting are less likely to be referred to services and less likely to refer themselves ([C4EO Safeguarding Briefing 1, Nov 2009](#)), http://www.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_1.pdf so it should not be assumed that they can advocate for themselves.

"Safeguarding is not only about very young children or indeed issues of class, but it extends across society and through the teenage years" ([The Protection of Children in England: A Progress Report. The Lord Laming, 2009](#))

<http://www.education.gov.uk/publications/eOrderingDownload/HC-330.pdf>

1.3 BACKGROUND

1.3.1 History of the protocol

1.3.1.1 The protocol came into existence in 1999, following the death of a baby whose mother was known to mental health services. It was revised in 2004 after publication of [Hidden Harm](#).

<http://www.homeoffice.gov.uk/publications/drugs/acmd1/hidden-harm>

In 2008 a further revision took place involving extensive consultation, including with young people.

1.3.1.2 The current revision includes a new section on parents with learning disability; a requirement of a Serious Case Review in 2009, following serious injury to a baby whose mother had a learning disability and following recommendations arising from Lord Laming's review of the protection of children.

1.3.2 Key principles

1.3.2.1 Local authorities have specific duties under the [Children Act 1989](#)

<http://www.legislation.gov.uk/ukpga/1989/41/contents>

in respect of children in need (Section 17) and children at risk of significant harm (Section 47). Those working with adults and children with substance use/misuse, mental health and learning disability problems in all health, social care and voluntary sector settings have a responsibility to safeguard children when they become aware of or identify a child at risk of harm, following Local Safeguarding Children Board (LSCB) procedures which are based on the Government Guidance [Working Together to Safeguard Children, DCSF 2010 \(WT2010\)](#). <http://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN-v3.pdf>

1.3.2.2 [Working Together 2010](#) states that "...children need to feel loved and valued, and be supported by a network of reliable and affectionate relationships.... If they are denied the opportunity and support they need to achieve these outcomes, children are at increased risk not only of an impoverished childhood, but also of disadvantage and social exclusion in adulthood. Abuse and neglect pose particular problems." ([WT 1.3](#)).

1.3.2.3 "Patterns of family life vary and there is no one perfect way to bring up children. Good parenting involves caring for the children's basic needs, keeping them safe and protected, being attentive and showing them warmth and love, encouraging them to express their views and consistently taking those views into account, and providing the stimulation needed for their development and to help them achieve their potential, within a stable environment where they experience consistent guidance and boundaries". ([WT 1.4](#)).

- 1.3.2.4 The government guidance [Working Together 2010](#), places the responsibility for the safety and welfare of children with the local authorities that are Children's Services Authorities but is clear that , "Everyone shares responsibility for safeguarding and promoting the welfare of children and young people, irrespective of individual roles" (WT 2.1) There is an expectation that health professionals that come into contact with children, parents and carers in the course of their work are aware of their responsibilities to safeguard and promote the welfare of children and young people (WT 2.61-2.66) and for GPs (WT 2.77, 2.84-2.87). The same expectations apply to those working in Adult Social Services (WT 2.28), Adult Mental Health Services (WT 2.102-2.105) and in the fields of Alcohol and Drug Services (WT 2.107).
- 1.3.2.5 All agencies involved in the care of such adults or children are expected to work closely together, share information and thoroughly assess to promote the welfare of a child or to protect a child from significant harm.

1.4 WHOLE FAMILY WORKING

- 1.4.1 In a system that 'Thinks Family', services for both adults and children join up around the needs of the family and set out what this system would look like to families on the ground. ([Think Family: Improving the Life Chances of Families at Risk, 2008](#)) <http://www.education.gov.uk/publications//eOrderingDownload/Think-Family.pdf>
- 1.4.2 Parenting at any stage, from pregnancy to when the child becomes an adult at eighteen, can be a challenge for any parent or carer, requiring a great deal of physical and emotional effort. Most parents and carers have the capability to provide good or good enough parenting for their children most of the time and are able to access universal services to support their health, education and leisure needs. Sometimes, a usually capable parent will have such overwhelming needs of their own that they may not have the capacity to be such a capable parent. If this is very short term, such as a parent being physically ill, then providing their physical and safety needs are met, most children have the resilience to overcome the stress of this with the support of their friends and family.
- 1.4.3 Universal services such as health, housing and education have a key role in identifying children and adults with additional needs and signposting families to specialist or other universal services. Staff in specialist adult services dealing with vulnerable parents should be alert to the needs of children and young people and think "**who do I need to work with?**" to help identify or meet their needs. This means that all those working with children, young people and their families are potentially involved in providing early prevention and/or intervention work in safeguarding children and their families.

1.5 EQUALITIES

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

1.6 CONFIDENTIALITY AND SHARING INFORMATION

- 1.6.1 "Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest. A public interest can arise in a wide range of circumstances, including the protection of a child from harm, and the promotion of child welfare. Even where the sharing of confidential medical information is considered inappropriate, it may be proportionate for a clinician to share the fact that they have concerns about a child." [The Protection of Children in England: a Progress Report The Lord Laming 2009.](#)
- <http://www.education.gov.uk/publications//eOrderingDownload/HC-330.pdf>
- 1.6.2 It is critical that **all practitioners** working with children and young people are in no doubt that where they have reasonable cause to suspect that a child or young person may be suffering significant harm or **may be at risk of suffering significant harm**, they should always refer their concerns to Children's Services (social care). While a practitioner's primary relationship may be with the parent, where there is cause for concern, information needs to be shared on a 'need to know' basis with the appropriate Children's Services (social care).

- 1.6.3 Practitioners should seek to discuss any concerns with the family and, where possible, seek their agreement to making referrals to child care services to optimise the care of children and protect them from harm. **This should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm.** The child's interest must be the overriding consideration in making any such decisions.
- 1.6.4 However where a child is not suffering, nor at risk of suffering, significant harm, parental permission is needed for the sharing of information. This should be raised with parents at the beginning of professional involvement following agency guidelines, with emphasis on the help and support which can be accessed by the family as a result of sharing information with other agencies. In general, information sharing is in the best interests of the person and supports delivery of effective treatment. In the process of finding out what is happening to the child, it is important to take into consideration their wishes and feelings.
- 1.6.5 Everyone should ensure that the information they share is proportionate and necessary for the purpose for which they are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely way and is shared securely. If in doubt, seek advice; this may be done without disclosing the identity of the person.
- 1.6.6 Consent or the refusal to give consent to information sharing about children should always be recorded. For further information see [Information Sharing: Guidance for practitioners and managers, HM Government, 2006](http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf), the aim of which is to support good practice in information sharing by offering clarity on when and how information can be shared legally and professionally, in order to achieve improved outcomes.

<http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf>

1.7 PARTNERSHIP WORKING

- 1.7.1 Safeguarding and promoting the welfare of children, and in particular protecting them from significant harm, depends upon effective joint working.
- 1.7.2 Sharing information is essential to enable early identification to help children young people and families who need additional services to achieve positive outcomes. See [What to do if you're worried a child is being abused 2006](http://www.education.gov.uk/publications/eOrderingDownload/6840-DfES-IFChildAbuse.pdf).

<http://www.education.gov.uk/publications/eOrderingDownload/6840-DfES-IFChildAbuse.pdf>

1.7.3 Systems should be in place to ensure that:

- managers working with adults can monitor those cases which involve dependent children
- there is regular, formal and recorded consideration of such cases with Children's Services (social care) staff
- if adult and children's services are providing services to a family, staff communicate and agree interventions
- appropriate staff are invited to relevant planning meetings
- staff participate in the relevant planning meetings.

(Pan-Hampshire Safeguarding Children Procedures 2007) www.4lscb.org.uk

1.8 COMMITMENT FROM SERVICES

1.8.1 Children's Services (Social Care)

1.8.1.1 Children's Services will receive and record contacts expressing concerns about risks to children. They will be clear with other agencies about their threshold for involvement and give feedback on what will happen as a result of a contact. They will be open to having discussions with other services regarding their concerns.

1.8.1.2 All contacts about concerns will be recorded, whether they trigger an assessment or not, and in the event of subsequent referrals being received, will contribute to building a picture of issues and concerns which may trigger further action, which will be fed back to referring agencies.

1.8.1.3 Children's Services will, throughout their involvement with children and their families:

- employ a policy of openness with families where information from other agencies impacts on planning for the child
- seek consent from family members to share information with other agencies in the best interests of the child (but bear in mind this should only be done if the discussion and agreement-seeking will not place a child at increased risk of significant harm - see 1.6.3)
- be clear whether an assessment using the Common Assessment Framework (CAF) has been undertaken and, if so, its outcomes
- assess the unborn child's needs and identify desired outcomes for the child
- assess the child's needs and identify desired outcomes for the child
- provide a child-focused service to families with whom they are involved
- ensure that the wishes and feelings of child/ren are ascertained
- ensure the child is given the opportunity to be seen/heard on their own, but be aware that the child's view of 'normality' and what is acceptable may be influenced by exposure to drug or alcohol abuse, or other factors (e.g. domestic abuse)
- check with substance misuse teams where parents are using drugs (a required check on the social work CP1 form) and particularly where there is an unborn or very young child and make sure that the assessment includes both partners, not just the mother
- consult with primary and secondary mental health services, learning disability and substance misuse teams for information to support assessment of parenting capacity, and for realistic assessment of any risk even where there are no apparent safeguarding issues, undertaking joint assessment where possible
- invite representatives from mental health, learning disability and substance misuse services to Child Protection Conferences where they are involved with the family
- together with relevant agencies, identify roles and responsibilities for any ongoing work with the family: a meeting is preferable where decisions need to be made and owned.

1.8.2 **Services working with adults**

1.8.2.1 Services working with adults will, throughout their involvement:

- identify at an early stage any children within families and specifically those with a caring responsibility
- ensure, when assessing adults' needs, that any support to help their parenting role is taken into account
- retain a family focus, ensuring that they are not focusing solely on the adult, making the children 'invisible'
- understand that although parental mental ill-health, learning disability or substance misuse, especially in combination with domestic abuse, does increase the risk that children may be harmed, it is not a predictor of harm or neglect
- invite representatives from Children's Services or other services to multi-professional care planning meetings where they are involved with the family, with the agreement of the service user
- provide a representative to attend Child Protection Conferences where at all possible or at the very least, provide a report
- ensure they are kept informed about plans for any children and incorporate these into future care planning.

1.8.3 **Working with parents and families**

1.8.3.1 Unless it places children at increased risk, it is important to engage with and involve families to reduce risk of harm to children. Evidence from help lines indicates "the possibility of seeking advice without losing control of what happens next is a way in which some children and families move towards seeking a service." ([C4EO Safeguarding Briefing 1, Nov 2009](#))

http://www.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_1.pdf

1.8.3.2 If it becomes apparent that a change of circumstances has occurred or the parent is not complying with services and this raises concern about the welfare of the child or there is a concern that the child is at risk of significant harm, a referral should be made to Children's Services (social care) in order that the appropriate action can be taken. These concerns may include:

- failure to attend for appointments
- failure to allow access for home visits
- avoidance of practitioners
- homelessness or family network breakdown
- deterioration in mental health, physical health, more chaotic substance misuse
- introduction of a new adult, child or young person into the home situation
- change of circumstances which may impact on risk or resilience.

1.9 CASE MANAGEMENT

- 1.9.1 Effective inter-agency communication and multi-agency co-operation is **crucial** to the management of on-going work with people with mental health, learning disability, substance misuse or other complex problems and their families. There must be clarity with regard to the different roles and responsibilities undertaken by different workers and a decision made regarding coordination, so that this is not left to the parent.
- 1.9.2 Practitioners in adult services may need to ask for the expertise of child practitioners and vice versa in assessment or for specific pieces of work.
- 1.9.3 When workers receive new information that is likely to affect a previous assessment of the impact of the adult's needs upon parenting, they must pass this information on to Children's Services (social care) and other agencies involved, so that, if necessary, a reassessment of the situation can be triggered.
- 1.9.4 Where a child is the subject of a Child Protection Plan, or is identified as a Child in Need, it is important to maintain a continuous dialogue between Primary Care, Adult Services, Mental Health Services, Drug/Alcohol Services and Children's Services Teams regarding treatment objectives. As with key workers below (section 1.10.3.4) professionals working directly with such families may be expected to participate in Child Protection Core Groups, where these are set up to monitor the progress of Child Protection Plans.

1.10 PLANNING MEETINGS

1.10.1 Common Assessment Framework (CAF)

- 1.10.1.1 The CAF provides a process for identifying children's needs and bringing services together to meet those needs more quickly and effectively. Further information on the CAF and locality teams can be found at:

<http://www3.hants.gov.uk/childrens-services/practitioners-information/caf-and-locality-teams.htm>

- 1.10.1.2 Each agency/organisation will have its own system with regards to undertaking an assessment using the CAF. If there is uncertainty about using the CAF advice should be sought from the relevant Children's Services Department.
- 1.10.1.3 Parents should be asked if a CAF has already been done and if so, who is the Lead Professional.

1.10.2 Other planning meetings

- 1.10.2.1 Practitioners should be aware of any other protection plans around family members e.g. Children in Need planning, Core Group, Team around the Child (TAC), MAPPA, MARAC, CPA and other multi-professional planning meetings and identify the need to be involved in those processes.

1.10.3 Child Protection Conferences (see 4LSCB procedures)

<http://www.4lscb.org.uk/documents/4lscbproceduresupdated220708.pdf>

- 1.10.3.1 Child Protection Conferences will be conducted in line with LSCB child protection procedures and the Children's Services Department Safeguarding procedure. It is expected that representatives from the appropriate statutory and voluntary agencies will attend Conferences, and if they cannot, that they will provide the Conference with a written report. Representatives may also be required to attend Core Group meetings, where detailed plans to protect children are made, following the Conferences.
- 1.10.3.2 GPs have a particularly important role to play because they hold key information regarding the family. They are the single point for holding an individual's health information and usually the first point of contact for a person with the health service.
- 1.10.3.3 Parents and where appropriate, children and young people, are encouraged to attend conferences. They may be excluded, however, if they are under the influence of substances at the time of the conference to such an extent that they are unable to participate effectively.

- 1.10.3.4 Parents are invited to bring someone to support them or an advocate to the conference. Their key worker from the Drug/Alcohol, Mental Health or Adult Services will always be invited to attend by the social worker where the needs of parents are seen to potentially impact on the child. The key worker will be part of the professional network and will be expected to contribute to the decision-making and be clear as to what their service can offer to the Child Protection Plan.

1.11 SUPERVISION

- 1.11.1 Supervision, guidance and support from someone with knowledge of safeguarding, is essential for people working with children, parents or carers where there are concerns that a child may be at risk of harm or neglect. Issues may be raised in formal structured supervision or unplanned discussions.

“To work with families with compassion but retain an open and questioning mindset requires regular, challenging supervision”. ([The Munro Review of Child Protection – Part One: A Systems Analysis, 2010](#))

<http://www.education.gov.uk/munroreview/downloads/TheMunroReviewofChildProtection-Part%20one.pdf>

- 1.11.2 It is crucial that all agencies establish a clear framework for supervision, guidance and support. Those supervising staff working with adults should always ask about the care of children in the family and those managing child care cases should always ask about collaboration with adult workers if there are substance or alcohol misuse, mental health or learning disability problems affecting parents.

1.12 TRAINING

- 1.12.1 All staff working with adults, who may have parenting responsibilities, should receive child safeguarding training appropriate to their role. There should be awareness raising regarding this protocol in every relevant agency with training related directly to this protocol ideally multi-agency.

2. Part 2: General guidance for all

2.1 RISK

- 2.1.1 The needs and issues facing some parents and carers are known to be associated with greater risks to both them and their children. This may relate to particular health or social behaviours of the parent or the danger to their physical health or well-being. This may be made worse by the social stigma attached to the problem of the parent or carer or by professionals being as overwhelmed as the parents/carers are by the complexity of dealing with the problems that they face.
- 2.1.2 The risks particularly associated with mental health, substance misuse and learning disability are dealt with within their specific sections. The risks for the children and parents are known to increase considerably when these factors combine with each other or with domestic abuse or other violent crime. ([Understanding Serious Case Reviews and their impact – A Biennial Analysis of Serious Case Reviews 2005 – 07, Brandon et al, DCSF](#))
- [http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR129\(R\).pdf](http://www.education.gov.uk/publications/eOrderingDownload/DCSF-RR129(R).pdf)
- 2.1.3 Assessing these risks is important and requires the practitioner not only to rely upon any standard risk assessment used in their particular field but to think broadly about risks to others and how these may be lessened through joint working.
- 2.1.4 Family members and other children living with a person with complex problems may be assessed as being a protective factor for a child. Whilst their opinion of risk is important, practitioners must assess the risk independently, as the family member may be too entrenched in the circumstances to be able to give an objective view.
- 2.1.5 “Risk management cannot eradicate risk; it can only try to reduce the probability of harm”.
- ([The Munro Review of Child Protection Part One: A Systems Analysis, Professor Eileen Munro, Department for Education 2010](#))

2.1.6 Most children and young people who are seriously harmed or killed are not involved with specialist mental health or probation services and subject to their risk assessments. They are much more likely to be receiving help and support through universal services such as those offered through the GPs, health visitors, walk-in centres, schools, voluntary sector or local council services such as housing.

2.1.7 The circumstances of people's lives and health can change frequently meaning that the stresses and risks both for individuals and the family also change and need frequent holistic re-assessment.

2.1.8 Risk to children

2.1.8.1 A number of Serious Case Reviews (Hackney, Birmingham <http://www.iscbbirmingham.org.uk/downloads/Case+14+New.pdf>) have highlighted the risk that some people with psychosis can be to their children; in rare cases leading to Filicide.

Munro & Rungay (2000) <http://bjp.rcpsych.org/cgi/content/abstract/176/2/116> argue that more homicides could be prevented by good mental health care, which detected relapse earlier. This includes those involving deaths to children.

In the Hackney SCR the mother had believed the children were not her own, having been swapped at birth. In the Birmingham SCR the father appears to have had delusional beliefs, linked to his faith beliefs leading to the failure to provide care for his child.

Having parents with psychosis can lead to emotional stresses in a family, which can have a negative effect on children in the family home.

2.1.9 Psychosis

2.1.9.1 Staff from any agency may observe people with psychosis.

They may be experiencing:

- **hallucinations** – where people see, hear, smell, taste and feel things that are not there
- **delusions** – where people have fixed false irrational belief; this may be paranoid, believing others may wish to harm them or their family
- **thought disorder**- where people speak quickly and incessantly (pressure of speech) or switch topic mid sentence (flights of ideas) or make irrational statements, believing things around them have changed in some way.

Early signs of psychosis may include:

- odd or bizarre behaviour
- severe deterioration of social relationships, social withdrawal or isolation
- inappropriate laughter, unexplained euphoric mood, feelings of depression or anxiety.

2.1.9.2 Psychosis is a symptom of a variety of conditions, which can include mental illnesses such as schizophrenia or bipolar disorder, but can also be associated with drug or alcohol misuse and sometimes physical conditions such as Parkinson's disease.

For some, a period of psychosis will last only a few days, for others, if untreated it can last for long periods. Some people only experience one episode of psychosis throughout their lives, while others may have several. Most psychosis is treatable.

2.1.9.3 If any practitioner believes that the person may be suffering from a delusion involving their children, which includes non-abusive thoughts, they **must** make a referral to Children's Service (social care).

If any practitioner believes a person may be at risk to children through other forms of psychotic ideas i.e. hallucinations they **must** also make a referral to Children's Services (social care).

2.1.9.4 It is important that if a practitioner feels that a person may be a risk from an **untreated** psychosis they alert the GP in order for the GP to arrange a mental health assessment. This includes if the person is unwilling or unable to seek help themselves. In some situations the GP can arrange an assessment under the Mental Health Act 1983, as amended 2007, if they believe the person to be a risk to themselves and/or others.

2.1.9.5 Comprehensive help is provided for people with psychosis throughout the area covered by this protocol. Accessing it is usually by a GP referral, however Early Intervention in Psychosis Teams accept self referrals and work with people from age 14-35 years.

2.2 YOUNG CARERS

2.2.1 “A young carer becomes **vulnerable** when the level of care-giving and responsibility to the person in need of care becomes **excessive or inappropriate for that child**, risking impact on his or her emotional or physical well being or educational achievement and life chances.” ([ADASS/ADCS MOU 2009](#)) <http://www.youngcarer.com/pdfs/AMOU.%20youngcarers.pdf>

2.2.2 [Carers \(Recognition and Services\) Act 1995](#) – young carers are entitled to an assessment of their needs separate from the needs of the person for whom they are caring.

<http://www.legislation.gov.uk/ukpga/1995/12/contents>

2.2.3 [Carers \(Equal Opportunities\) Act 2004](#) – identification of young carers can be problematic. Many children live with family members with stigmatised conditions such as mental illness and/or drug and alcohol problems. In many cases, families fear what professional intervention may lead to if they are identified. Some families may also have concerns about stigmatisation of being assessed under children’s legislation.

<http://www.legislation.gov.uk/ukpga/2004/15/contents>

2.2.4 [The Children’s Plan \(DfES 2007\)](#) states that: for young carers – “services should adopt a whole family approach. This means that children’s and adult services must have arrangements in place to ensure that no young person’s life is unnecessarily restricted because they are providing significant care to an adult with an identifiable community care need”.

<http://www.dcsf.gov.uk/childrensplan/>

2.2.5 For services to provide effective support for young carers and their families, it is vital that all members of staff working with them begin with an inclusive, wide-ranging and holistic approach that considers the needs of:

- the adult or child in need of care
- the child who may be caring and
- the family

2.2.6 Young carers identified the following concerns:

- gaps in the support of the person they cared for and the wider family
- impacts on their own wellbeing, personal development and education and pressures on their everyday lives
- lack of recognition by the NHS, PCTs, GPs and schools about their needs as children who are also young carers
- the need for closer joint working across adult social care and children's services to ensure better outcomes for children and the person who is supported ([Carers at the heart of 21st- century families, and communities, HM Government, June 2008](#))

<http://static.carers.org/files/carers-strategy-pdf-3377.pdf>

2.2.7 There are an estimated 50,000 to 200,000 young people in the UK caring for a parent with mental health problems. ([MyCare, The Challenges Facing Young Carers of Parents with a Severe Mental Illness, Mental Health Foundation, December 2010](#))

<http://www.mentalhealth.org.uk/publications/?entryid5=83759&p=3&char=M>

2.3 PARENTAL TREATMENT – EFFECTS ON CHILDREN

2.3.1 Consideration of the needs of parents in relation to access to treatment e.g. for their substance misuse or mental health problems, should be seen in the wider context of the effect on the whole family. Whilst accessing treatment is a positive step for the parent it may have a negative impact on children; for a child it may mean taking on more caring responsibilities for their parents, both practically and emotionally or separation from a parent.

2.3.2 Building on the National Treatment Agency (NTA, DH, DCSF 2009) [Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services and Supporting Information for the Development of Joint Local Protocols](#) (December 2010 still in draft), workers need to consider:

does the parent need childcare support to access treatment?

- what care arrangements need to be in place for the parent to access hospital, a detox/rehab unit or home detox?
- who is offering the child support?
- that adult's crisis or contingency plan includes a plan for care of the child
- will the parent need support getting the child to and from nursery/school?
- liaison with school or early years service
- what is the child's understanding of the parent's treatment, does the parent need support in explaining what will happen?
- referral to young carers services for the child carer
- referral to Children's Services (social care) if they consider the child may be at risk of harm
- referral to Children's Services (social care) if a child is likely to be cared for outside their immediate family for more than 28 days (private fostering) <http://www.privatefostering.org.uk/?gclid=CIGIzuqf3aYCFQZO4Qodhj2i0w>

2.3.3 Staff should also be aware that successful treatment of parents, allowing them to resume their caring responsibilities might mean a loss for the child of the role they had previously undertaken or a change in the dynamics of the relationship between the child and parent which may have an adverse effect on the child.

2.4 PSYCHOLOGICAL OR EMOTIONAL DISTRESS

2.4.1 In addition to mental health, substance misuse and learning disability, the following situations, which may cause psychological or emotional distress, are associated with increased risks to the whole family and for most will require support from friends, family and possibly services:

- transitions and unexpected life events such as separation, divorce, bereavement, discharge from health or social care services, incarceration and release from prison, return to civilian life from armed forces - on leave from active service or at end of service
- social isolation
- hate crime
- pregnancy (a common trigger for the start of domestic abuse [WT 9.23](#))
- financial difficulties

2.4.2 Domestic Abuse/Violence

2.4.2.1 Domestic abuse is defined by the Home Office as “Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality”. This includes issues of concern to black and minority ethnic (BME) communities, such as so called ‘honour based violence’, female genital mutilation (FGM) and forced marriage (FM).

Domestic abuse frequently co-exists with child abuse. The main characteristic of domestic abuse is that the behaviour is intentional and is calculated to exercise power and control within a relationship.

Nearly a quarter of adults in England are victims of domestic violence/abuse. ([Home Office 2009. What is Domestic Violence?](#))

<http://rds.homeoffice.gov.uk/rds/violencewomen.html>

2.4.2.2 Domestic abuse rarely exists in isolation and may contribute to drug or alcohol misuse, and poor physical and mental health. Parents may also have a history of poor childhood experiences themselves. Domestic abuse compounds the difficulties parents experience in meeting the needs of their children and even if there is no physical violence, it has been shown to have a serious negative impact on children and young people at each stage of their development leading to health, behavioural, educational and social difficulties.

2.4.2.3 The presence of domestic abuse in a family increases the likelihood that children and young people will experience abuse and/or neglect. The risk of physical harm to both the victim and children increases around the time of separation and may continue as subsequent contact arrangements are made. ([Working Together to Safeguard Children 2010 DCSF](#))

2.4.2.4 From January 2005 the legal definition of harm to children was extended to include the impairment suffered from seeing or hearing the ill treatment of another – particularly in the home, even though they themselves have not been directly assaulted or abused. ([S120 Adoption and Children Act 2002](#))

<http://www.legislation.gov.uk/ukpga/2002/38/section/120>

2.4.2.5 200,000 out of 11 million children in England live in a household where there is a known high risk case of domestic abuse ([The Protection of Children in England: A Progress Report 2009 the Lord Laming](#)). In 75-90% of incidents with domestic violence, children are in the same or next room ([The Munro Review of Child Protection Interim Report: The Child's Journey 2011](#)).

For detailed guidance see Safeguarding Children Abused through Domestic Abuse in the 4LSCB procedures www.4lscb.org.uk

2.4.3 **Parents who offend**

2.4.3.1 All agencies should be aware of the impact of a prisoner returning to the family home. Additionally, there is specific guidance for Police and Courts around arrest and sentencing of offenders with responsibilities for children. ([Around Arrest, Beyond Release. Experiences and needs of Families in Relation to the Arrest and Release of Drug Using Offenders, August 2007, Tackling Drugs Changing Lives](#))

2.4.3.2 Within HMP Winchester and Kingston there have been projects running to support prisoners in their role as fathers, to strengthen family relationships and to increase the stability of the children's lives to enable them to achieve positive outcomes. Partners in these projects are the Prisons, Local Authorities, Probation, Sure Start Children's Centres and Jobcentre Plus.

2.4.4 **Parents who kill their children**

2.4.4.1 Parents who kill or seriously harm their children are not always known to services. In analyses of SCRs over the years it has been found that approximately 50% of the cases were not known to Children's Services (social care) but they may have been known to other children's or adult's services.

2.4.4.2 Men are more likely to kill their children than women. The additional risk factors for men appear mixed and may relate to:

- being a violent individual or previously known to commit violent crimes
- being a perpetrator of domestic abuse
- undergoing, or there being a threat of, a separation from a partner
- being emotionally distressed and having difficulties that bring feelings of loss, shame or hopelessness. This may be associated with emotional difficulties, prior abuse or linked with loss of work, housing difficulties or money worries. This may be linked with suicide.

- 2.4.4.3 The killing of children is often linked to the mother of the child being killed at the same time. In these circumstances the perpetrator may appear to be “more ordinary” than other murderers. ([Dobash et al 2007 Murder in Britain](#)).
- 2.4.4.4 Although such murders are unpredictable, many are thought to be pre-meditated. It is therefore important to offer additional support to fathers, recognising the importance of their role within the family. ([Flynn, S. Windfuhr, K. and Shaw, J, Filicide: A Literature Review. The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness, Centre for Suicide Prevention, The University of Manchester, 2009](#))
- http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/reports/filicide_a_literature_review.pdf
- 2.4.4.5 There is a higher proportion of infanticide by females after the time of a baby’s birth. This appears related to puerperal psychosis or the mother being unable to face the reality of being pregnant or a mother. (See section 3.3.3)
- 2.4.4.6 Most of the serious case reviews identified sources of information that could have contributed to a better understanding of the children and their families. This included information about or from fathers and extended family, historical knowledge, information from other agencies, the cultural background and research findings. ([Ref: Learning Lessons from Serious Case Reviews 2009-10. Ofsted](#))
- <http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Statistics/Other-statistics/Learning-lessons-from-serious-case-reviews-2009-2010>
- 2.4.4.7 Learning from SCRs has also highlighted the need to identify if family members are being supported by different GP Practices, as a result of personal choice or urgency. If this is the case then effective information sharing needs to be prioritised if concerns are raised. ([HSCB SCR Child Q](#))

Appendix 1 Further reading/resources

- [NICE Clinical Guideline CG 89 When to suspect child maltreatment: full guideline, December 2009](http://guidance.nice.org.uk/CG89/Guidance/pdf/English)
<http://guidance.nice.org.uk/CG89/Guidance/pdf/English>
- [SCIE Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare, July 2009](http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf)
<http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf>
- [No health without mental health. HM Government February 2011](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766
- [Young Minds](http://www.youngminds.org.uk/)
<http://www.youngminds.org.uk/>
- [Keeping the Family in Mind: a briefing on young carers whose parents have mental health problems](http://www.barnardos.org.uk/keeping_the_family_in_mind.pdf)
http://www.barnardos.org.uk/keeping_the_family_in_mind.pdf
- [Royal College of Psychiatrists resources](http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/parentalmentalillness.aspx) <http://www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/parentalmentalillness.aspx>
- [Safer baby guidance – see fsid website](http://fsid.org.uk/page.aspx?pid=406)
<http://fsid.org.uk/page.aspx?pid=406>

3. Part 3: Specific/additional guidance: mental health

3.1 DEFINITION

3.1.1 This protocol refers to people with mental health problems, from mild and moderate to severe and enduring mental ill health and including eating disorders and personality disorders. It is important that all workers should be aware that the term 'mental health problems' covers a range of illnesses some requiring brief intervention in primary care, while others require referral to specialist mental health services.

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

3.2 IMPLICATIONS FOR AND EFFECTS ON PARENTING

3.2.1 The Royal College of Psychiatrists states that "data indicate that 10-15% of children in the UK live with a parent who has a mental disorder and 28% of those are the children of lone parents with a mental disorder" ([Parents as patients: supporting the needs of patients who are parents and their children CR 164, January 2011](#))

<http://www.rcpsych.ac.uk/publications/collegereports/cr/cr164.aspx>

3.2.2 "Most parents with mental illness do not abuse their children and most adults who abuse children are not mentally ill." However, there are well-established links between parental mental disorder and poor outcomes for children. These can be felt from conception onwards and into adult life. ([Parents as patients: supporting the needs of patients who are parents and their children CR 164, January 2011](#))

- 3.2.3 The 2011 guidance offers the following advice:
- “Although many parents with mental illness and their children can be remarkably resilient, adverse outcomes for children are associated with parental mental disorder. Hence, psychiatrists and other mental health professionals in any speciality must consider the family context of service users and consider the well-being and safety of any dependent children at any stage of the care process from assessment to discharge. This will involve working closely with other agencies, across boundaries, sharing information as appropriate and remembering that a child’s needs are paramount even in situations where the necessary safeguarding action may impair the therapeutic relationship with the parent.”*
- 3.2.4 The mental health of both fathers and mothers and any effect on the child need to be considered. Where both have a mental illness, the adverse effects on children may increase.
- 3.2.5 All parents find parenting challenging at times, and those with a mental health need often show considerable inner strength in adequately parenting their child. Being a parent with a mental health need, however, may be particularly challenging. Many parents are painfully aware that their disorder affects their children even if they do not fully understand the complexities. [\(Falkov A \(ed 1998\) Crossing Bridges: Training resources for working with mentally ill parents and their children. Brighton: Pavilion Publishing\)](#)
- 3.2.6 “Any assessment should measure the potential or actual impact of mental health on parenting, the parent/child relationship, the child as well as the impact of parenting on the adult’s mental health. Appropriate support and ways of accessing it should also be considered in the assessment.”
- [\(Parents as patients: supporting the needs of patients who are parents and their children CR 164, January 2011\)](#)
- 3.2.7 Parental personality factors (pre-existing and/or exacerbated by the illness) may mean parents have difficulty controlling their emotions, have an inability to cope or be self-preoccupied. Violent, irrational and withdrawn behaviour can frighten children.
- 3.2.8 The lack of capacity to parent well may not be the only reason for poor outcomes for children whose parents have mental illness. Factors such as the effects of poor housing, financial difficulties, domestic abuse, or hostile neighbourhoods may be a significant factor in parental stress and illness. [\(Stanley et al \(2003\) Child Protection and Mental Health Services: Interprofessional responses to the needs of mothers. Bristol: The Policy Press\)](#)

- 3.2.9 Unmet mental health needs can lead to the child taking on responsibilities beyond their years because of their parent's incapacity. This may include becoming a carer for the parent and/or other children or family members.
- Children may understand when things are not right and if their needs are not being met. They may not be able to, or want to say anything about it, or there may be no-one to tell; they may just get on with it by taking on inappropriate caring roles for their families. (see young carers, section 2.2)
- 3.2.10 Questions about childcare and parenting issues are clearly sensitive and can have important implications for people with mental health needs. The stigma associated with mental illness may make parents reluctant to ask for help.
- Fear of a child being removed from their care has been expressed by parents as an obstacle to seeking help for mental health needs or fully engaging with services. Practitioners need to be aware of this fear and should work with the parents and families openly, building on their strengths.
- 3.2.11 Families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas. It is government policy to promote the well being of children through timely and appropriate support.
- 3.2.12 All children even young children are sensitive to the environment around them. Thus their parents' state of mind can have an effect on even the youngest child. In this context, all children are vulnerable when a parent has a mental illness but children may be helped considerably where the parent is aware of this. ([Stanley et al. 2003](#))
- 3.2.13 Strengths in the family, such as the ameliorating effects of another adult, can minimise the effects on children of the mental illness of a parent.
- 3.2.14 Identifying the impact of these stresses on the child is an important factor in the initial assessment for the child and the care plan for the parent and reinforces the need to see mental health needs of parents/carers in the context of family life and functioning.
- 3.2.15 It is essential that an appropriate assessment of the parent/carer's needs is undertaken to assess the impact on any child involved with the family. Children have a right to have their own needs assessed, receive appropriate services and to be heard in their own right so that risk factors can be identified and minimised and protective factors promoted. In this way, children can be enabled to achieve their full potential.

3.2.16 To safeguard children of parents with whom they are working, mental health practitioners should routinely record details of parents' responsibilities in relation to children and consider the support needs of parents and of their children in all aspects of their work. ([Working Together to Safeguard Children 2006 paras 2.93-2.94](#)). This should include consideration of whether the adult is likely to resume contact with a child from whom they have been separated.

3.2.17 In General Practice, as a result of personal choice, urgency, inflexible appointment systems or failure to utilise appointment systems appropriately, patients with serious mental health problems may not see the same GP on a regular basis. Where patients with serious mental health problems are referred to the Community Mental Health Team, there needs to be consistency of practitioner and information sharing. **In these cases it is recommended that, where practicable, one named GP monitors the patient's care and receives correspondence.** ([Child Q SCR Recommendation, HSCB July 2010](#))

3.2.18 **In cases where service users express delusional beliefs involving their child and/or they may harm their child as part of a suicide plan, a referral to Children's Services (social care) must be made immediately.** ([National Patient Safety Agency Rapid Response Report May 2009](#)).

<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59898&p=2>

The report details recommendations that must be actioned, the key points of which are:

- are there any children in the household?
- does the service user have contact with children in their working or social network?
- if there is no current contact with children will this be resumed in the future?
- in secondary care, a consultant psychiatrist should be directly involved in clinical decisions if the service user may pose a risk to children.

3.3 PRENATAL AND POSTNATAL PERIOD

3.3.1 Specific concerns apply to the pre- and post-natal periods. It is vital that there is joint working between the General Practice, Midwifery, Health Visiting and if involved, specialist Mental Health Services. It is essential to identify needs, assess and prepare safeguarding plans for both mother and child. (See Appendix 3 for information from NICE guideline)

- 3.3.2 Post-natal depression (PND) is very common among new parents and may affect as many as 1 in 6 new mothers, typically in the first 3 months after delivery, sometimes lasting for 6 months or up to a year if left untreated. Maternal post-natal depression can be significantly harmful to young infants particularly from birth to 12 months of age with increased incidence of insecure attachment. (Cox. A.D, Puckering. C, Pound. A, and Mills, M (1987) *The impact of maternal depression in young children. Child Psychology and Psychiatry*, vol 22, no 6 pp917-28)
- (Murray, L. Hipwell, A. and Hooper, R (1996) *Cognitive development of 5 year old children of postnatally depressed mothers. Child Psychology and Psychiatry*. vol 37, no 8, pp 927-35)

It is not the depression itself which causes damage, it is its impact on the mother's ability to interact with and respond to her child. Prolonged non-availability of the primary carer can lead to emotional and cognitive difficulties, social withdrawal, negativity and distress.

- 3.3.3 Puerperal Psychosis is a disorder which affects 1-2 women per 1000. It is potentially a very serious illness often requiring hospitalisation. The onset can be very rapid within hours of birth although it often develops over days sometimes weeks. Women with an existing diagnosis of Bi-Polar Disorder or who have a close family member with this are at significantly greater risk of developing Puerperal Psychosis and should be referred to a Perinatal Mental Health Service during pregnancy to agree a post delivery management plan.

Appendix 2 Summary of potential impact on child of primary and secondary behaviours associated with parental psychiatric disorder

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

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

Appendix 3 Antenatal and Postnatal Mental Health

The NICE Guideline on Clinical Management and Service Guidance

(CG 45, 24 April 2007)

<http://www.nice.org.uk/nicemedialive/11004/3043/30431.pdf>

At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers 'yes' to either of the initial questions.

Is this something you feel you need or want help with?

4. Part 4: Specific/additional guidance: substance misuse

4.1 DEFINITION

4.1.1 When referring to substance misuse this guidance will apply to the misuse of alcohol as well as 'problem drug use', defined by the Advisory Council on the Misuse of Drugs (ACMD) as drug use which has:

'serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them'.

4.1.2 'Substance' is used to refer to any psychotropic substance (capable of affecting the mind – changing the way we feel, think and or behave) including:

- alcohol
- tobacco
- drugs sold as 'legal highs'
- illegal drugs
- illicit use of prescription drugs
- volatile substances such as solvents (gases, lighter and other fuel)
- some plants and fungi (magic mushrooms)
- over-the-counter and prescribed medicines that are used for recreational rather than medical purposes.

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

4.1.4 Substance use/misuse by parents/carers does not, on its own, automatically mean that children are at risk of abuse or neglect, but workers must recognise that children of problematic substance users are a high-risk group. Furthermore, adults who misuse substances may be faced with multiple problems, including homelessness, accommodation or financial difficulties, difficult or damaging relationships, lack of effective social and support systems, issues relating to criminal activities and poor physical/and or mental health.

Parents or carers who experience domestic abuse may use substances as a coping mechanism. Substance misuse may cause or exacerbate abuse within a relationship. Assessment of the impact of these stresses on the child is as important as the substance misuse. It reinforces the need to see substance misuse by parents/carers in the context of family life and functioning, and not purely as an indicator or predictor of child abuse and neglect.

4.2 GUIDANCE

4.2.1 This protocol is written in line with the National Treatment Agency's (NTA) [Models of Care](#), DCSF's [Think Family' Toolkit](#), and DH's [Models of Care for Alcohol Misusers \(MoCAM\)](#), copies of which should be available to all staff in all agencies.

http://nta.shared.hosting.zen.co.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf,

<http://www.education.gov.uk/publications//eOrderingDownload/Think-Family.pdf>

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136809.pdf

4.2.2 Hidden Harm is defined by the ACMD as "Parental problem drug use and its actual and potential effects on children" (ACMD, 2003). For the purpose of this guidance the term includes the misuse of all drugs specifically including alcohol.

4.2.3 In response to concerns around the children of drug misusing parents, the ACMD produced a report in June 2003 outlining a series of 48 recommendations. From the inquiry, six key messages emerged:-

- (1) We estimate there are between 250,000 and 350,000 children of problem drug users in the UK – about one for every problem drug user
- (2) Parental problem drug use can and does cause serious harm to children at every age from conception to adulthood
- (3) Reducing the harm to children from parental problem drug use should become a major objective of policy and practice
- (4) Effective treatment for the parent can have major benefits for the child
- (5) By working together, services can take many practical steps to protect and improve the health and well-being of affected children
- (6) The number of affected children is only likely to decrease when the number of problem drug users decreases.

<http://www.homeoffice.gov.uk/publications/drugs/acmd1/hidden-harm?view=Binary>

4.3 **IMPLICATIONS FOR AND EFFECTS ON PARENTING**

4.3.1 More than 2.6 million children in the UK live with hazardous drinkers and 705,000 live with a dependent drinker. ([The Munro Review of Child Protection. Interim Report: The Child's Journey, 2011](#)) 25% of the cases reviewed in the [Biennial Analysis of Serious Case Reviews 2005-2007 DCSF, 2009](#) featured parental substance misuse. Many of those cases were not known to Children's Services.

<http://www.education.gov.uk/munroreview/downloads/Munrointerimreport.pdf>

<http://education.gov.uk/publications/eOrderingDownload/DFE-RR040.pdf>

Having children may lead some parents to enter treatment and stabilise their lives, but in other cases their children may be at risk of neglect or serious harm or take on inappropriate caring roles.

4.3.2 The following situations relating to a child or children should raise suspicion and will need further investigation/referral:

- abnormal or delusional thinking about a child
- persistent negative views expressed about a child
- hostility, irritability and criticism of a child
- inconsistent and/or inappropriate expectations of a child
- emotional detachment from child
- lack of awareness of child's needs that might require attention e.g. illness
- keeping a child at home to provide care (see young carer, section 2.2)
- family income used for drug/alcohol purchase rather than basic essentials
- child's safety compromised by drugs, alcohol and paraphernalia not safely stored in the home
- child exposed to criminal activity connected to substance misuse child exposed to contact with other substance misusing adults who may pose risks either in or outside the home
- domestic abuse
- disruption to relationships with the extended family, reducing the protective factor for children

4.4 PREGNANT WOMEN WHO MISUSE DRUGS AND/OR ALCOHOL

4.4.1 These guidelines are intended to ensure a clear and consistent policy for those working with pregnant women who use substances, with a view to encouraging their co-operation with the relevant agencies. The overall objective is to ensure the physical well being of both the mother and baby, and enable the baby to be safely discharged from the hospital to the care of the mother wherever possible. Consideration should be given to the resources needed to support the family.

Addressing the issues early in the pregnancy will give greater opportunity for attendance at antenatal appointments, engagement with substance misuse services and modification of lifestyle.

See Maternity Services and Children's Social Care Joint Working Protocol to Safeguard Unborn Babies www.4lscb.org.uk

4.4.2 Substance misuse is often associated with poverty and other social problems, therefore pregnant women may be in poor general health, as well as having health problems related to drug use. As a general principle, substance misuse during pregnancy increases the risk of:

- having a premature baby
- having a baby with a low birth weight
- the newborn suffering symptoms of withdrawal from drugs used by the mother and requiring medication or other treatment
- the death of the baby before or shortly after birth
- an irritable and less responsive baby
- the newborn acquiring HIV, hepatitis C and/or hepatitis B infection
- 'sudden infant death syndrome' (SIDS)
- physical and neurological damage to the baby, particularly if violence accompanies parental use of drugs or alcohol
- the baby suffering from 'foetal alcohol spectrum disorder' (FASD) or 'foetal alcohol syndrome' (FAS) when the mother drinks excessively.

References:

- Mactier H. [The management of heroin misuse in pregnancy; time for a rethink? Arch Dis Child Fetal Neonatal Ed 20120 June 28,](#)
- Prentis S [Obstetrics, Gynaecology and Reproductive Medicine. September 2010 \(Vol 20, Issue 9, Pages 278-283\),](#)
- [Substance misuse in pregnancy; a resource pack for professionals in Lothian. Whittaker A 2nd Edition 8th March 2010 © NHS Lothian.](#)

4.4.3 As the benefits to the baby far outweigh any risks, mothers who are substance misusers should be encouraged to breastfeed in the same way as other mothers, including in the case of breast-feeding with HIV, hepatitis C and/or hepatitis B infection, but always with specialist advice.

4.4.4 Drug withdrawal symptoms at birth referred to as 'neonatal abstinence syndrome' (NAS) can occur in infants born to mothers dependent on certain drugs. They may make the baby more difficult to care for in the post-natal period. These babies may be nursed with their mothers on the postnatal ward unless they require treatment.

4.4.5 The pregnant substance user is likely to feel guilty about the harm she may be causing to the baby and fearful of the judgment of others. As soon as any agency comes into contact with a pregnant woman who is misusing substances, they should inform maternity services of their involvement, highlighting any concerns and offer reassurance to the pregnant woman that all agencies will work with her to enable her to care for her baby and that the baby will not automatically be removed or be made subject to a Child Protection Plan because of her substance misuse. Some pregnant drug users do not come for antenatal care until late pregnancy fearing judgmental attitudes, Children's Services (social care) involvement, conflict with partners or having to give up drug use.

Appendix 4 Summary of Potential Impact of Parental Drug Misuse
(taken from Hedy Cleaver. The Child's World, Assessing Children in Need, Reader DoH (2000))

| Age (years) | Health | Education and Cognitive Ability | Relationships and Identity | Emotional and Behavioural Development |
|-------------|--|---|---|--|
| 0 - 2 | Substance misuse during pregnancy may result in symptoms of withdrawal. Missed medical check-ups and immunisations. Unsuitable clothing, very poor hygiene. | Cognitive development of the infant may be delayed through parents' inconsistent, under-stimulating and neglectful behaviour. | Care of children by different strangers at different times can lead to insecure attachments. | A lack of commitment and increased unhappiness, tension and irritability in parents may result in inappropriate responses and emotional insecurity in the child. |
| 3 - 4 | Children may be placed in physical danger by excessive parental drug misuse, <i>and by the presence of drugs in the home.</i> Children's physical needs may be neglected. | Lack of stimulation. Nursery or pre-school attendance may be irregular. | Children may take on responsibilities beyond their years because of parental incapacity. | Children may be at risk because they are unable to tell anyone of their distress. |
| 5 - 9 | School medicals and dental appointments missed. Psychosomatic symptoms e.g. sleep problems, bed-wetting. | Academic attainments may be negatively affected and children's behaviour in school may become problematic. | Children may develop poor self-esteem and may blame themselves for their parents' problems. Because they feel shame and embarrassment over their parents' behaviour, children may curtail friendships and social interactions. | Conduct disorders with boys e.g. hyperactivity, inattention. Depression and anxiety in girls Children may be in denial of their own needs and feelings. |
| 10 - 14 | Little or no support during puberty because of parental emotional withdrawal. Early experimentation with substances more likely. | Continued poor academic performance due to caring for siblings or parents. Higher risk of school exclusion. | Restricted friendships. Poor self image and low self esteem. | Children are at increased risk of emotional disturbance and conduct disorders, including bullying. They are also at risk of becoming drug misusers themselves. |
| 15+ | Increased risk of problem substance misuse. Risk of pregnancy, STIs and failed relationships. | Poor life chances due to poor school attainment or exclusion because of behavioural problems. | Lack of appropriate role models. | Emotional problems may result from self-blame and guilt, and lead to increased risk of suicidal behaviour and vulnerability to crime. |

Appendix 5 Summary of Potential Impact of Parental Alcohol Misuse

| Age (years) | Health | Education and Cognitive Ability | Relationships and Identity | Emotional and Behavioural Development |
|-------------|--|---|---|--|
| 0 - 2 | Health risks to children include direct physical harm, including risk of serious injury or death by overlaying parents failing to ensure that the environment is safe and harm caused by impaired physical concentration, can lead to problems completing breastfeeding or nappy changing. | Possible delay in cognitive development due to lack of appropriate and consistent stimulation. | Attachments to parents may be problematic or insecure because of inconsistent and chaotic behaviour and emotional withdrawal. Children can feel loss and abandonment if drinking behaviour is placed above child's needs. | Infants may have unsuitable clothing and poor hygiene. Indifference and despair that can accompany problem drinking can mean parents do not respond to or reassure their child in appropriate and positive manner – may lead to child to believe they are unloved and unlovable. |
| 3 - 4 | When a parent is intoxicated the ability to care for children can decline, and children can be at risk from both direct physical harm and neglect. Children may be left home alone or with unsuitable carers if parents place their drinking behaviour above child's needs. | Child may have cognitive deficit due to insufficient emotional stimulation and interaction. Nursery or pre-school attendance may be irregular since problem drinking often results in parents being disorganised or inactive. | Children commonly blame themselves for family's problems and attempt to put things right in vain and attempt to make their environment better able to support them. | Children may be more at risk of emotional disturbance as they cannot easily articulate emotions. The level of this disturbance may be missed as child's behaviour does not always reflect their mental state. |
| 5 - 9 | Children may experience head and stomach aches, allergies, sleeping problems and bed-wetting. | Academic performance may be negatively affected with school attendance, punctuality, preparation and concentration also potentially affected. In contrast, some children may immerse themselves in their studies and attain well. | Children may suffer from low self-esteem and feel that they are not in control of events in their life. They may find it harder to see themselves as an individual separate to the family problems. | Girls may internalise the depression, fear, anxiety and stress caused by their parent's inconsistent and chaotic behaviour, by withdrawing into make-believe. Boys may externalise the distress, resulting in conduct problems, hyperactivity and lack of concentration. |

| Age (years) | Health | Education and Cognitive Ability | Relationships and Identity | Emotional and Behavioural Development |
|-------------|---|--|--|--|
| 10 - 14 | Children may receive no support through puberty because of parental emotional withdrawal. They may have difficulty in developing healthy and balanced attitudes to alcohol as a result of parental alcohol use – experimentation with alcohol and other drugs may be more likely. | Academic performance may be negatively affected due to children's concern about parental problem drinking, which can lead to children staying at home to care for family. | If parents' lives revolve around drinking, children may develop low self-esteem and blame themselves for the drinking. If income is directed primarily at parents' drinking, children may find it hard to maintain an acceptable appearance, causing them to be highly self-conscious, and may lose friendships as a result. | Children may externalize the distress caused by parental drinking problems, resulting in conduct problems. These ways of externalizing/internalising difficult feelings can lead to children being labelled or identified as 'the problem' by their families and others. |
| 15+ | Can lead teenagers to drinking extremes, either mirroring their parents' problem drinking or abstaining. Risk of pregnancy, STIs and failed relationships are higher if parents, who may be emotionally withdrawn, do not discuss these issues with teenagers. | Caring responsibilities can impact negatively on a teenager's education and their future employability. If excluded from school, parents may be incapable of getting children back into school or supporting their continued learning. | If parents' behaviour is inconsistent and chaotic, children may have low self-esteem, feel rejected, isolated, unable to control events in their life. | Teenagers may show extremes of behaviour that are beyond parental control. Adolescents may resort to stealing when income is spent on parental drinking, and this criminal and anti-social behaviour may bring them into contact with the Criminal Justice System. |

Appendix 6 Summary of Protective Factors in relation to parental substance misuse

| Age (years) | Health | Education and Cognitive Ability | Relationships and Identity | Emotional and Behavioural Development |
|-----------------|---|--|--|---|
| 0 - 5 | <p>Good regular ante-natal care.</p> <p>Support for the expectant mother of at least one caring adult.</p> <p>Medicines and illicit drugs are safely stored.</p> <p>Sufficient income and good physical living standards.</p> | <p>Regular supportive help from primary health care team and Children & Families.</p> | <p>The presence of a caring adult who responds appropriately to the child's needs.</p> | <p>The presence of a caring adult who responds appropriately to the child's needs.</p> |
| 5 - 9 | <p>Attendance at school medicals.</p> | <p>Regular attendance at school.</p> <p>Sympathetic, empathetic and vigilant teachers.</p> | <p>A supportive older sibling. Children who have at least one mutual friend have higher self-worth and are less lonely than those without. Social networks outside the family, especially with a sympathetic adult of the same sex. Belonging to organised out-of-school activities.</p> <p>Being taught different ways of coping and knowing what to do when parents are incapacitated.</p> | <p>The presence of an alternative, consistent, caring adult who responds appropriately to the child's cognitive and emotional needs.</p> |
| 10 – 15+ | <p>Factual information about puberty, sex and contraception.</p> | <p>Regular school attendance.</p> <p>Sympathetic, empathetic and vigilant teachers. A champion who acts vigorously on behalf of the child. For those no longer in school, a job.</p> | <p>A mentor or trusted adult to whom the child can discuss sensitive issues. Practical and domestic help.</p> | <p>A mutual friend. Unstigmatised support of relevant professionals.</p> <p>The ability to separate themselves either psychologically or physically from stressful family situations.</p> |

5. Part 5: Specific/additional guidance: learning disability

5.1 DEFINITION

- 5.1.1 The British Psychological Society defines learning disability as assessed impairments of both intellectual and adaptive/social functioning which have been acquired before adulthood. Each learning disability condition or syndrome has different symptoms and behaviours associated with it and the way in which these manifest themselves can and do depend on the individual.
- 5.1.2 The most recent research estimates that there are 985,000 adults in England with a learning disability, equivalent to an overall prevalence rate of 2% of the adult population. Estimates of the number of adults with learning disabilities who are parents vary widely from 23,000 to 250,000.

5.2 GUIDANCE

- 5.2.1 The DH published ([Valuing People DH, 2001](http://www.archive.official-documents.co.uk/document/cm50/5086/5086.htm)) <http://www.archive.official-documents.co.uk/document/cm50/5086/5086.htm> to help promote the rights of people with learning disabilities. Since then there have been a number of initiatives and guidance documents aimed at supporting people with learning disabilities. DH guidance ([Good Practice Guidance on Working with Parents with a Learning Disability June 2007](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075118.pdf)) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075118.pdf says people with learning disabilities have the right to be supported in their parenting role, just as their children have the right to live in a safe and supportive environment.

5.3 IMPLICATIONS FOR AND EFFECTS ON PARENTING

- 5.3.1 Parents with learning disabilities frequently face challenges in their home environment; they often live with their own parents or family members which reduces any personal control they have over the domestic environment or the parenting of their children.

- 5.3.2 Parents with learning disabilities face a high risk (50%) of having their children removed into care, usually as a result of concerns for the children's well-being and/or an absence of appropriate financial, practical and social support to perform their parenting role effectively. [Booth et al \(2005\) Care proceedings and parents with learning difficulties: comparative prevalence and outcomes in an English and Australian court sample. *Child and Family Social Work*, 10, 353-360](#)
- 5.3.3 Parents will need support and reasonable adjustments to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly important when parents experience additional stressors such as having a disabled child, domestic abuse, poor physical and mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. It is these additional stressors when combined with a learning disability that are most likely to lead to concerns about the care and safety of a child.
- 5.3.4 Research evidence highlights the need for independent advocacy when parents with learning disabilities are at risk. "Parents with learning disabilities also need to have access to the same level of information and advice available for all parents." ([Valuing People Now, DH, 2009](#))
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf
- 5.3.5 Teenagers may be more able than their parents, if the parent(s) have a learning disability, and are likely to take on the parenting role, becoming responsible for housework, cooking, correspondence, dealing with authority figures, and the general care of their parents and younger siblings. (see young carer, section 2.2)
- 5.3.6 Many parents with learning disabilities do not meet eligibility criteria for Adult Services. **However it is important to remember that under the Fair Access to Care criteria any safeguarding issues escalate eligibility status to critical or substantial.**
- 5.3.7 If you have any concerns about the children of adults with learning disability, you should contact your local Adult Services learning disability team to establish if the adult is known to services or make a referral through normal routes.

5.4 PRENATAL AND POSTNATAL PERIOD

- 5.4.1 Specific concerns apply to the pre and postnatal periods. It is vital that there is joint working between GPs, Midwifery, Health Visiting and if involved, specialist Learning Disability Services. It is essential to identify needs, assess and, if necessary, prepare safeguarding plans for both mother and child.

5.4.2 Parents with a learning disability will require additional support before the baby is born to understand what is happening, with easy read information, understandable antenatal classes and support at checkups.

5.4.3 Parental learning disability may impact on the unborn child because it affects parents in their decision-making and preparation for the birth. The quality of the woman's ante-natal care is often jeopardized by late presentation and poor attendance. When women with learning disabilities do attend antenatal care they may experience difficulty in understanding and putting into practice the information and advice they receive.

5.4.4 Parents with a learning disability may struggle to adjust to developmental changes in the child, i.e. eating solid food, walking and may need additional support at these times.

GLOSSARY

| | | |
|-------|--|--|
| ACMD | Advisory Council on the Misuse of Drugs | An independent expert body that advises government on drug related issues in the UK. |
| CAF | Common Assessment Framework | The CAF is a standardised approach to conducting assessments of children’s additional needs and deciding how these should be met; used by practitioners across children’s services in England. |
| CAMHS | Child and Adolescent Mental Health Services | NHS services providing help and treatment for children and young people and their families with emotional, behavioural and mental health difficulties. |
| | Child Protection Conference | A confidential meeting between parents, social services child protection workers and other professionals to discuss the welfare of a child(ren), after an enquiry has shown that a child(ren) is at risk of abuse or neglect and to agree what needs to be done to reduce this risk. |
| | Child Protection Plan | Plan to detail risks to a child; to clarify what needs to change to reduce or eliminate the risk; tasks that parents and professionals need to undertake with timescales, targets and monitoring arrangements. |
| | Children’s Services (social care) or Children’s Services | Local Authority Department with wide statutory responsibilities for children, including safeguarding. Any other reference to ‘services for children’ relates to all statutory and non-statutory services. |
| | Core Group | A group of identified professionals who have a key role to play in the Child Protection Plan, along with, where appropriate, the parents and child. Together the Core Group has responsibility for developing, implementing and reviewing the Child Protection Plan ensuring the welfare of the child remains paramount. |
| CPA | Care Programme Approach | Planning process for people who use secondary mental health services. May also be used in Substance Misuse Services and CAMHS. |
| Detox | Detoxification | Treatment for addiction to drugs or alcohol intended to remove the physiological effects of the addictive substances. Can be undertaken as an in-patient or in the community. |
| DH | Department of Health | Government Department with remit to improve the health and wellbeing of people in England. |

| | | |
|----------|---|--|
| DA or DV | Domestic abuse or violence | Domestic abuse is any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. |
| EIP | Early Intervention in Psychosis Team | Secondary mental health specialist service for people aged 14-35 offering help, assessment, treatment and support to young people and their families in the early stages of a psychotic illness. |
| FAC | Fair Access to Care | Eligibility criteria that adult social care departments use to determine whether a person is entitled to receive services they provide or commission. DH Guidance 2002. |
| | Filicide | The deliberate act of a parent killing their own son or daughter. |
| | Harmful drinking | Defined as when a person drinks over the recommended weekly amount (21 units for men and 14 units for women) and has experienced health problems directly related to alcohol. |
| | Hazardous drinking | Defined as when a person drinks over the recommended weekly limit. Can include binge drinking within weekly limits. Not yet experiencing related health problems. |
| | Infanticide | Homicide of an infant by a mother. |
| | Lead Professional | When a child or young person with multiple needs requires support from more than one practitioner, the lead professional acts as a single point of contact that the child or young person and their family can trust and who is able to support them in making choices and navigating their way through the system, ensuring they get appropriate interventions when needed, which are well planned, regularly reviewed and effectively delivered. |
| | Legal highs | Intoxicating drugs which are not prohibited. |
| LSCB | Local Safeguarding Children Board | Key statutory mechanism within each Local Authority for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children. There is one in Hampshire, Isle of Wight, Portsmouth and Southampton. |
| MAPPA | Multi-Agency Public Protection Arrangements | Statutory arrangements supporting the assessment and management of the most serious sexual and violent offenders. |

| | | |
|---------|--|---|
| MARAC | Multi-Agency Risk Assessment Conference | Process combining risk assessment and a multi-agency approach to help very high risk victims of domestic abuse. |
| NICE | National Institute for Health and Clinical Excellence | An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill-health. |
| NTA | National Treatment Agency | An NHS special health authority established to improve the availability, capacity and effectiveness of drug treatment in England. |
| Ofsted | Office for Standards in Education, Children's Services and Skills | Regulatory and inspection office with aim of achieving excellence in the care of children and young people, and in education and skills for learners of all ages. |
| | Perinatal | During pregnancy and for twelve months after birth. |
| | Practitioners | Any local paid or volunteer staff who might come into contact with parents with complex needs or their children. |
| Rehab | Rehabilitation | Frequently residential provision following detox. to enable people to address non-treatment specific issues relating to their drug or alcohol problems, usually funded by Adult Services. See detox above. |
| | Serious Case Review | Local enquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. Carried out by LSCBs, they are currently evaluated by Ofsted. |
| STI | Sexually Transmitted Infection | Diseases passed on through intimate sexual contact; common STIs in the UK include chlamydia, genital warts and gonorrhoea. |
| TAC | Team around the child | A way of working with children and young people who through the use of the CAF or initial assessment have been identified as having unmet needs, and require support from more than one agency/service to meet these needs. |
| | Universal services | Services available to the general public e.g. GPs, health and education services. |
| WT 2010 | Working Together to Safeguard Children, Department of Children, Schools and Families, 2010 | Department of Education guide which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004. |

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