BOLTON SAFEGUARDING CHILDREN BOARD

JOINT PROTOCOL

WORKING WITH PARENTS / CARERS WHO HAVE MENTAL HEALTH PROBLEMS

JANUARY 2014
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Contents

1. INTRODUCTION

1.1 Vision

Children's need for protection and the presence of mental disorder in the parent / carer is bound to overlap at times. In such situations it is important to maintain a balance between the awareness of risk that mental disorder may represent to a child's safety and/or wellbeing and the need to protect individuals with a mental disorder from being stereotyped and disadvantaged. Informed assessments and effective multi-agency working are the key to ensuring that children and families receive the appropriate services to meet their identified needs and manage risks. Adult Mental Health Services including those providing general adult and community, forensic psychotherapy, alcohol and substance misuse and learning disability services have a responsibility in safeguarding children when they become aware a child's welfare is not being promoted, or identify a child at risk of harm.

Families who are in need of services from both children's services and Adult Mental Health Services should be assured of seamless and integrated support.

1.2 Objectives

The objectives of this protocol are: -

- To meet the needs of children whose parents / carers have mental health problems.
- To promote joint working between Children's Services and Mental Health professionals in both the statutory and non-statutory sectors.
- To promote joint training to help professionals understand each other's perspectives and assist joint practice.
- To encourage work which is non discriminatory. This means that whilst the safeguarding and safety of the child is paramount, agencies also have a responsibility to adopt a non discriminatory, open and supportive approach and ensure adequate advocacy is provided to the parent / carer.

2. SHARED PRINCIPLES

Families have a right to expect that services will be provided in line with a common set of guiding principles: -

- Children's needs are best met when parents are supported but the needs of the child are paramount.
- Parents with a mental illness have the right to be provided with care and support that can enable them to meet the needs of their child/children.
- Children have the right to be protected from harm and to receive services when their health or development is at risk.
- All professionals involved have a responsibility for promoting the safety and wellbeing of children.

- A multi-agency approach to specialist assessment and service provision is in the best interests of both parents and children. Information gathering and assessment should be based on the principle of effective joint working across Adult and Children's Services.

- Risk is reduced when information is shared effectively between agencies.

- Risk to children is reduced through effective multi-agency and multi-disciplinary working.

- Services should be needs-led with the child's needs being paramount.

- Services should recognise diversity and actively cater for individuals' ethnic, religious and cultural needs and personal preferences.

- Parents and children should have a say in how their services are provided and have real opportunities to be involved in developing and improving services.

3. FRAMEWORK GUIDELINES

3.1 Mental Health Framework

Adult Mental Health Services work under the legal framework of the Mental Health Act 1983 (as amended 2007) and associated guidance and the Mental Capacity Act 2005 and associated guidance.

Adults Services Departments including Greater Manchester West Mental Health NHS Foundation Trust have duties under Section 47 of the NHS and Community Care Act 1990 to undertake assessments of need and arrange services to meet those needs.

"Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community" (DOH 1994) stated Health Authorities and Children and Young People's Service Departments will need to ensure that the Care Programme Approach (CPA) and care management arrangements are properly coordinated.

"Effective Care Coordination in Mental Health Services" (the 1999 DOH Policy document on the modernisation of the CPA and its integration with Care Management) requires a systematic assessment of the health and social care needs of individuals with mental health problems, with a care co-ordinator responsible for implementing and reviewing their care plan.

There is a duty incumbent on all mental health practitioners to consider the needs of children and to consult with colleagues in Children's Social Care whenever concerns or queries about their welfare arise

3.2 Children's Social Care Framework

Children's Services work under the legal framework of the Children Act 1989 and associated guidance.

Section 17(1) of the Children Act 1989 states that: -
"It shall be the general duty of every Local Authority (in addition to the other duties imposed on them by this part) –
a) to safeguard and promote the welfare of children within their area who are in need; and
b) *so far as is consistent with that duty, to promote the upbringing of such children* by their families, by providing a range and level of services appropriate to these children's needs".

Section 17(10) says: *"…a child shall be taken to be in need if -*

a) *he is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health and development without the provision of services by a Local Authority;*

b) *his health or development is likely to be significantly impaired, or further impaired without the provision for him of such services; or*

c) he *is disabled".*

A child is a child under the meaning of the Children Act 1989 until s(he) reaches their 18th birthday.

Section 47(1) of the Children Act 1989 states that: -
Where a Local Authority:

a) are informed that a child who lives, or is found, in their area -
   i) is the subject of an Emergency Protection Order; or
   ii) is in police protection; or
   iii) has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter 1 of Part 1 of the Crime and Disorder Act 1998; or

b) have reasonable cause to suspect that a child who lives, or is found in their area, is suffering or is likely to suffer, significant harm, the Authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

The aforementioned Section 17 and Section 47 represent the main areas of work with children and families whose needs range from simple to the more complex.

The Children Act 1989 introduced the concept of 'significant harm' and in the context of Section 47 is the threshold that justifies compulsory child protection intervention in the best interest of children. (See Bolton's framework for action 2007)

3.3 Multi-Agency Framework

Working Together to Safeguard Children" (20)13) sets out how all agencies and professionals are required to work together to promote children's welfare and protect them from abuse and neglect. It describes how actions to safeguard children fit within the wider context of support to children and families

"Working Together" specifies that all professionals working in mental health services in the statutory, voluntary and independent sectors should bear in mind the welfare of children, irrespective of whether they are primarily working with adults or with children and young people.

In the provision of services to service users each agency will have principles, practices, philosophies and ethics pertinent to their profession. However, the Children Act 1989 established an unambiguous principle, the *"Paramouncy Principle"* which states that the welfare of the child is paramount in any concerns about possible abuse.

The Children Act (2004) Section 10 requires Local Authority's Mental Health Services and partner agencies to cooperate with the intention of improving the wellbeing of children and Section 11 identifies the duty of all practitioners to safeguard and promote the welfare of children whilst carrying out their role

Bolton's Framework for Action provides all those working with children and their families across the town, with a process to identify and respond to children's needs. In Bolton the process for working with children and families that do not meet the threshold of significant harm is by using the Common Assessment Framework (CAF) (see http://www.boltonsafeguardingchildren.org.uk/page/EarlyInterventionandIntegratedWorking.aspx) lead professional and child action meetings process. This process facilitates multiagency working and ensures additional needs are identified early and appropriate services provided in line with the Munro recommendations.

The Common Assessment Framework (CAF) is a practical and simple process to help identify additional support needs. It's a way of working with a child, young person and/or their family at the earliest opportunity to help make things better. The process includes:

- an assessment tool based on the National Assessment Framework;
- an action planning and review process;
- a way of recording and sharing information where needed to access and coordinate additional services.

The CAF is not just a form; it is a process that includes the completion of paperwork via discussion and engagement with children, young people and families. It is also a recognised suitable tool to share information with consent.

Child Action meetings are used to bring together parents, professionals and where relevant, the child. The purpose is to identify and deliver a holistic service to improve the outcomes for children. This process should be used at levels one and two of the Framework for Action when two or more agencies are involved to ensure roles are clear, plans are co-ordinated and reduce any potential duplication or confusion.

4. WORKING TOGETHER

Where Children's Social Care and Mental Health Services are involved with an individual or family, a representative from each service must be invited to attend any meetings concerning the family. For Mental Health Services the most common meetings would include ward based multi-disciplinary team meetings (where leave and discharge arrangements are discussed see section 10), Care Programme Approach (CPA) reviews and Adult Protection meetings, multi-disciplinary assessment meetings. For Children's Social Care the most common meetings would include Child Action meetings, Child Protection Strategy meetings, Child Protection conferences and Core groups

5. IMPACT OF MENTAL HEALTH ON CHILDREN AND FAMILIES

Parental mental illness does not automatically have an adverse impact on children but it can increase their vulnerability. It is also possible for different children within the same family to have a different experience of parenting and therefore for different needs to emerge. Therefore it is essential to always assess its implications for each child in the family. (Many children whose parents have mental ill health may be seen as children with additional needs requiring professional support and in these circumstances all adult mental health workers should consider the need for a Common Assessment Framework CAF.)

Where a parent / carer has either mental and/or physical illness, their children may have caring responsibilities, which are inappropriate to their age. These responsibilities must be recognised

and may have an adverse effect on children's' development and in these circumstances the need for a Common Assessment Framework (CAF) should always be considered.
Some forms of mental illness may blunt parents / carers' emotions and feelings or cause them to behave in bizarre, violent or inconsistent ways towards their children or environment.

- At the extreme a child may be at risk of severe injury, profound neglect, or even death.

- A study of 100 reviews of child deaths (A Falkov 1996, DOH) where abuse or neglect had been a factor in the death, showed clear evidence of parental mental illness in one third of cases – more up to date research which was published in October 2010 by Ofsted referenced learning lessons from serious case reviews.

- Post-natal depression can also be linked to both behavioural and physiological problems in the infants of such mothers.

- Where the other parent / carer or family members can help, or where the problems are mild, or short-lived and where there is no other family disharmony, the adverse effects on the children will be less likely.

- Significant history of domestic abuse is a risk indicator for children.

- Significant history of substance misuse is a risk indicator for children.

- Parental non-compliance with services and treatment is a risk factor.

- Stigma and oppression might impair parenting capacity of adults, and children might carry the burden of covering for parental behaviour.

A child at risk of significant harm or whose wellbeing is affected could be a child: -

- Who features within parental delusions;

- Who is involved in his/her parents suicidal thoughts or plans;

- Who is involved in his/her parent's obsessive compulsive behaviours;

- Who becomes a target for parental aggression or rejection;

- Who has caring responsibilities inappropriate to his/her age;
- Who may be exposed to unsuitable care givers if the parent/carer is vulnerable and unable to protect a childs or young persons well-being or safety

- Who may witness disturbing behaviour arising from the mental illness (e.g. self harm, suicide, disinhibited behaviour, violence, homicide);

- Who is neglected physically and/or emotionally by an unwell parent;

- Who does not live with the unwell parent, but has contact (e.g. formal unsupervised contact session or the parent sees the child in visits to the home or on overnight stays);

- Who is socially isolated because they feel unable to either bring other children home, or understand or have the words to explain what is happening at home to adults.

- Who is at risk of severe injury, profound neglect or death;

Or s/he could be an unborn child: -

- Of a pregnant woman with any previous major mental disorder, including disorders of schizophrenia, any affective or schizoaffective disorder; also severe personality disorders involving known risk of harm to self and/or others, or significant episode of postnatal depression or puerperal psychosis from a previous pregnancy.

The following factors may impact upon parenting capacity and increase concerns that a child may have suffered or is at risk of suffering significant harm: -

- History of mental health problems with an impact on the sufferer's functioning;
- Unmanaged mental health problems with an impact on the sufferer's functioning;
- Maladaptive coping strategies;
- Misuse of drugs, alcohol, or medication;
- Severe eating disorders;
- Induced fabricated illness disorder;
- Self-harming and suicidal behaviour;
- Lack of insight into illness and impact on child, or insight not applied;
- Non-compliance with treatment;
- Poor engagement with services;
- Previous or current compulsory admissions to mental health hospital;
- Disorder deemed long term 'untreatable', or untreatable within time scales compatible with child's best interest;
- Mental health problems combined with domestic abuse and/or relationship difficulties;
- Mental health problems combined with isolation and/or poor support networks;
- Mental health problems combined with criminal offending (forensic);
- Non-identification of the illness by professionals (e.g. untreated post-natal depression can lead to significant attachment problems);
- Previous referrals to LA children's social care for other children

Please see appendix 2 for Children's Services checklist and Mental Health Services checklist to support the assessments.

6. SHARED ASSESSMENTS

If the mental health professional identifies that the child / children are in need of additional support because of their parent / carer's mental health, they should discuss this with their line manager, the parent / carers and children and reach an agreement to use the CAF process, checking with the Integrated Working team whether there is already a CAF in place. The first

Child Action Meeting will be arranged by the person who has completed the Common Assessment Form with the child or young person, this may in some instances be the Mental Health worker. Once it has been agreed at a Child Action Meeting who will take on the Lead Professional role, they will co-ordinate any further Child Action Meetings and the ownership of the CAF will be transferred to them.

Shared assessments with Children's Services social worker and Mental Health professional should be undertaken between agencies to facilitate assessments and safeguard children when it is recognised and agreed that it is necessary to do so. The mental health professional involved in the assessment would normally be the care coordinator for Care Programme Approach (see glossary). In urgent situations where the person is not known to Mental Health Services the relevant team manager will appoint a mental health professional to undertake a joint assessment.

Professionals from all partner agencies who have involvement with the family or for whom there is a role in the future should be involved in joint assessments. For example in cases of post natal depression, health professionals should be involved.

It is important that assessments start and take place within agreed timeframes as required by the agencies' performance frameworks (see below). Copies of completed Children and Families Single assessment documentation including plans and outcomes should be shared in a timely manner.

Children's Service social work assessment processes at level 4:-

- Children's Services social work Single Assessment will be completed within a period ranging from 15 to 45 working days of the decision to undertake the assessment.

- An Initial Child Protection Conference should take place within 15 working days of the last Strategy Discussion.

- The first Core Group Meeting stemming from Child Protection Initial Conferences should take place within 10 working days of the Initial Conference and thereafter at monthly intervals.

- The first Child Protection Review should take place within 3 months of a child protection plan being implemented and thereafter at six monthly intervals.

- All agencies will be expected to provide relevant reports which express a professional view of the situation and recommendations for the child protection process.

7. REFERRAL TO BOLTON MENTAL HEALTH SERVICES

The majority of people with mental health problems will be assessed and supported by professionals working in a primary care setting. The most frequent mental health problems are depression, eating disorders and anxiety disorders. Most of these difficulties can be effectively treated in primary care. For those whose difficulties are assessed as being more severe, professionals working in a primary care setting will make a referral to specialist services for further assessment (National Service Framework for Mental Health). The most common referral route for specialist assessment is via a GP. Appendix 1 provides a glossary of the different types of mental illness.

People with a severe and enduring mental health problem will be supported by Community Mental Health Teams (CMHT's). In Bolton there are three teams, two organised into North and

South localities for those people with a functional disorder (see glossary) and one borough wide for people with dementia and complex care need. In addition there is a specialist borough wide team for young people with psychosis; the Early Intervention Team.

North CMHT tel:	01204 544640
South CMHT tel:	001204 544640
Dementia and Complex Care CMHT:	01204 462558/462674
Early Intervention Team tel:	01204 544640

Wherever a concern is raised about parental mental ill health,or someone with caring responsibilities for children experiencing mental ill health , this concern must be discussed with the GP involved and/or a mental health professional. Each CMHT operates a duty system. The duty worker will check whether a parent / carer is known, provide advice or accept a referral. .

Any referrals must be checked on adult systems e.g. CareFirst and ICIS and children's systems e.g. Liquid Logic to determine whether a family member is known to either service or whether there are any professionals currently involved where child concerns are indicated. They will agree to undertake relevant checks in line with confidentiality procedures, with agreement that information released is on a need to know basis in line with local safeguarding board procedures.There may also be concerns that a person experiencing mental ill health has access to children or a young person under the age of 18 and there may be child welfare concerns eg.friends of the parents or issues outside of the childs or young persons home. The duty worker in Childrens services will check if the child(ren)/parent(s) are known and provide advice or accept a referral.Similarly the CMHT duty worker will check if the friend or parents/carers are known and provide advice or accept a referral.

People who receive a service from a CMHT may experience a mental health crisis. If a mental health crisis does occur they can be referred to the Crisis Resolution Home Treatment Team (CRHT) for prompt and intensive support, this intervention ceases when the crisis has resolved. Throughout any involvement from CRHT ongoing care and treatment is organised by the person's care coordinator. CRHT tel: 01204 390745

Mental Health emergencies are referred to the Approved Mental Health Professional (AMHP) on duty for an assessment under the Mental Health Act 1983 (as amended 2007). Mental Health emergencies out of hours are referred to the Emergency Duty Team (EDT).

8. REFERRAL TO BOLTON CHILDREN'S SOCIAL CARE SERVICE

If the actions under targeted services for children – level 3 do not address the children's needs adequately and a more intensive package of protection and support is required, this should be decided at a child action meeting and the case be elevated to Level 4 with the lead professional making a referral to the referral and assessment team for an initial assessment.

If the child/children are at immediate risk of significant harm, a child protection referral should be made to the referral and assessment team and followed up in writing using the CAF template (within 2 working days). **Please note a child protection referral should be made at any point during the process if professionals have a concern that the child/children are at risk of significant harm (Level 4: Bolton's multi-agency threshold criteria).**

Where a practitioner is unsure as to whether a referral to the referral and assessment team is warranted the team duty social worker should be contacted and s/he will provide advice and guidance.

North referral and assessment team tel: 01204 337408
South referral and assessment team tel: 01204 337730
West referral and assessment team tel: 01942 634625

After accepting the referral the social worker will: -

- Check if CMHT is or has been involved with any person under enquiry or their partner. In the case of a check with Mental Health Services the initial contact should be made with the duty officer within the relevant CMHT. They will agree to undertake relevant checks in line with confidentiality procedures, with agreement that information released is on a 'need to know' basis in line with Local Safeguarding Children Board procedures.

- Initial information gathering in a Section 47 enquiry should also include checks with GP's and the CMHT if: -
    - There is an indication of mental disorder in a parent / carer or concern that mental illness may be present.
    - The person already has contact with Mental Health Services.
    - The Local Authority have a duty to make enquiries (under Section 47 of the Children Act 1989) if they are informed that a child has suffered or is likely to suffer significant harm.

Permission should of course be sought from the adult concerned where possible. Please refer to the information section below.

A decision should be made at this stage about whether it is appropriate to partner with the CMHT in visiting and assessing the circumstances. Should there be a need for a child protection plan then the child protection plan and the CPA care plan should not discriminate against the parent with a mental disorder and any tasks or actions for parents should be appropriate to their level of ability remembering that the needs of the child are paramount.

9. INFORMATION SHARING

Information sharing is a crucial element of successful multi-agency working supporting professionals to carry out their obligations and make informed decisions based on accurate and up to date information.

Informed consent must be sought from the parent / carer to share information unless: -

- The situation is urgent and there is not time to seek consent;

- Seeking consent is likely to cause serious harm to someone or prejudice the prevention, detection of serious crime

If consent to sharing recorded information is refused or can / should be sought from the parent / carer, information should still be shared in the following circumstances: -

- If information shared without consent it should be recorded with the reason why

- There is reason to believe that not sharing is likely to result in serious harm to the child or someone else or is likely to prejudice the prevention or detection of serious crime

- The risk is sufficiently great to outweigh the harm or prejudice to anyone that may be caused by the sharing and there is a pressing need to share the information

10. CHILDREN VISITING MENTAL HEALTH WARDS

When an adult is admitted to an inpatient mental health ward the admitting nurse should enquire whether the patient has parental responsibilities or regular contact with children. They should note any child care issues on the nursing assessment documentation.

Issues of note may include: -

- Details of who is looking after the child/children
- Any concerns about the care of the child/children whilst the patient is on the ward
- Any issues about visiting
- Issues about leave and discharge arrangements where the adult is a parent of has caring responsibilities for children

Any involvement of other agencies especially children's social care and whether the child/children has an allocated social worker. If this is the case the nurse in charge will contact Children's Services and social worker to ensure collaborative work to safeguard the children and make plans for contact where appropriate.
The children's social worker will assist inpatient staff to assess whether it is in the interests of a particular child to visit a named patient (LAC(99)23). Where a child has an allocated social worker this person should be contacted otherwise staff should contact the relevant referral and assessment duty social worker. Before leave and discharge arrangements are in place, where there are safeguarding concerns regarding children they will be discussed with the child / children's allocated social worker or a referral will be made to the referral and assessment team by the nurse in charge.

The Directions and associated guidance to Hospital Authorities (HSC 1999/160) sets out the assessment process to be followed when deciding whether a child can visit a named patient in special hospitals. When a Children and Young People's Service Department considers it has powers under the Children Act 1989 to undertake the necessary assessment, it should assist the hospital by assessing whether it is in the interests of a particular child to visit a named patient (LAC(99)23).

(HSC1999/222:LAC(99)32) to NHS Trusts, Health Authorities and Children & Young People's Service Departments re paragraph 23.3 of the revised Mental Health Act 1983 Code of Practice (Published April 1999) states that:
"Hospitals should have written policies on the arrangements about the visiting of patients by children, which should be drawn up in consultation with local Children & Young People's Service Authorities. A visit by a child should only take place following a decision that such a visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed."

Refer to Greater Manchester West Mental Health NHS Foundation Trust Child Visiting Policy

APPENDIX 1

Definitions of Mental Illness

There have been many attempts at defining mental illness and definitions vary depending on the severity of the symptoms. The Mental Health Act 1983 (as amended 2007) does not offer clear definitions of mental illness and as yet there is no universally agreed definition. The Health of the Nation booklet: *"Mental Illness - What does it mean?"* (HMSO) states:

"There are many different types of mental illness. Often these involve feelings of depression, anxiety and confusion – all of which most people get some time or other, particularly after a distressing life event such as bereavement. But with mental illness these feelings occur to such an extent for such a long period of time that they make it very difficult for a person to cope with everyday life."

The booklet offers further specific definitions:

Psychosis (functional disorder)
"your ability to distinguish between what is real and what is imaginary is seriously affected.. you might hear people saying things when no one is speaking – 'hearing voices' – which sound quite real to you. Or you may develop strong persistent beliefs or 'delusions' which are unbelievable to others around you who you know well"

Neurosis (functional disorder)
The booklet only briefly mentions neurosis and states that it is a broad term to describe anxiety and depression and that it has been used in such a vague way for so long that it is being used less and less.

Schizophrenia (functional disorder)
"…a condition that affects the most basic mental functions that give people their sense of individuality, uniqueness and direction. It can cause them to hallucinate (e.g. hear voices), develop feelings of bewilderment and fear, and to believe that their deepest thoughts, feelings and acts may be known to, or controlled by others".

Bi-Polar Disorder (functional disorder)
"…causes profound changes in mood, from severe depression and lethargy to elation and over-activity".

Depressive Disorder (functional disorder)
"…a condition in which feelings like depression, loss of interest, reduced energy, suicidal thoughts, and sleep and appetite disturbance go beyond normal mood changes".

Anxiety states (functional disorder)
"…phobic, panic and general anxiety disorders in which anxiety symptoms, such as worry, tension, over breathing and giddiness, cause significant distress and disability".

Dementia (organic disorder)
"leads to a decline in a person's intellectual functioning and memory. People can become very confused. Their memory for current events is impaired, but they are often able to recall scenes from many years ago with great clarity".

Eating Disorders (functional disorder)

"…include Anorexia Nervosa, a condition that leads to severe weight loss, and Bulimia Nervosa, a condition that combines over eating with vomiting or 'purging'. Both disorders are characterised by an extreme fear of being fat".

Personality Disorders (functional disorder)

"..are deeply ingrained patterns of behaviour which are inconsistent and inflexible responses to a broad range of personal and social situations. They may be associated with distress and problems in social functioning. There are several types of personality disorder. For example, some people are so shy or dependent that they find it distressing and difficult to make friends".

Other helpful definitions: -

Post Natal Illness (functional disorder)

As the name suggests, postnatal depression is like other forms of depression, but is brought on by having a baby. There are three main forms:

1. "The baby blues", which is the mildest form. This comes 2 to 4 days after delivery, and is so common that it is regarded as normal.
2. Postnatal depression. This affects one mother in six. It can occur any time in the first year of the baby's life, but seems most common when the baby is between four and six months old. The onset may be sudden or gradual, and the effects vary from mild to severe.
3. Puerperal psychosis. Affects one mother in 500. The behaviour of the mother may become increasingly bizarre and disturbing to those around her and she may lose touch with reality

Dual diagnosis (functional disorder)

The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex.

- Primary psychiatric illness leading to substance misuse
- Substance misuse can worsen or alter course of psychiatric illness
- Intoxication and/or substance dependence leads to psychological symptoms
- Substance misuse and/or withdrawal leads to psychiatric symptoms or illness

Although this definition talks about illness and substance misuse, the term is also used when two psychiatric illnesses are concurrent.

APPENDIX 2

Children's Service Checklist

- What behaviour of the parent where there is a mental health issue causes you concern – self- care, home conditions, relationship with partner (if applicable)?
- Do they have a known history of mental health problems or treatment?
- Have you observed them with their children? What are your observations?
- Have you consulted with, e.g. Young Carers' Project, Health Visitor, Family Centre, General Practitioner, School, Relatives?
- Ask the parent about their view of their mental health problem.
- Ask the parent if they have received treatment from their General Practitioner or a Consultant Psychiatrist for their mental health problem (record details of diagnosis, drug treatment, in-patient treatment).
- If applicable have you spoken to their partner and got their views?
- Have you spoken to the children (where age appropriate)? What do they feel about the situation? What do they want to happen?

Mental Health Services Assessment Checklist

- Nature of the mental disorder or illness that affects the care of the children, e.g. psychosis, depression, personality disorder.
- How might this impact on the care of the children? (physical care, emotional care, stimulation).
- Is there evidence that it is impacting on their care? What is it?
- Have you observed the parent with the children?
- What awareness does the parent have about the effect of their mental health problem on the care and well-being of their children?
- Support networks: -
    - What informal support systems are available for the care of the children (partner, family, voluntary agencies)?
    - What formal support systems are available for the care of the children (Health Visitor, General Practitioner, Homecare, Childminder, Day Nursery, School)?
- Are there any known resilience factors for the children? Do they have adequate support?

Notes

- Children's Services refers to **all** staff involved in delivering a service to children, adolescents and their families. And similarly, Mental Health Services refers to **all** staff, both community and hospital based, involved in the delivery of mental health services. Please note that we expect all services contracted out to be consistent with this policy and procedure. Performance will be reviewed at contract performance meetings.

- Care Programme Approach – This was introduced to focus on the health and social care needs of people with mental illness referred to specialist mental health services to ensure they receive continuity of care and support in the community.

- Severe and Enduring Mental Health Problems – "A mental disorder (i.e. psychotic disorders including schizophrenia, bi-polar disorder or severe neurotic conditions and personality disorders) of such intensity that it disables people from functioning adequately as determined on the basis of their culture and background."

- Primary Care – People with depression, anxiety and other neurosis will present directly to the General Practitioner, or another Primary Health Care Team member (Health Visitor, Practice Nurse, etc). People with these types of problems will make up the majority of people with mental health problems seen in general practice.

APPENDIX 3

Glossary and Contacts

Referral and Assessment Team	North: 01204 337408 South: 01204 337430/29 West: 01942 634625
Emergency Duty Team	01204 337777
Safeguarding Children Unit	01204 337479
Named Nurse GMW	:Dr Karen Clancy 0161 773 9121
Named Doctor GMW	Dr Kenny Ross: 0161 773 9121
Children's Services	Refers to all staff involved in delivery of services to children, adolescents and their families
Adult Mental Health Services	Service provision for adults with mental health problems provided by Greater Manchester West Mental Health NHS Foundation Trust
North Functional CMHT	01204 544640
South Functional CMHT	01204 544640
Dementia and complex care CMHT	01204 462558 /462674
Early Intervention Team	01204 544640
CAM	Child Action Meeting
Care Coordinator	The qualified mental health professional who coordinates mental health care under CPA for individuals with mental health problems
Care Management	The process (as CPA) used by Children and Young People's Service
CIN	Child in Need
CMHT	Community Mental Health Team
CPA	Care Programme Approach. The government framework to provide effective mental health service delivery
Single Assessment	Assessment over a period ranging from 15-45 days resulting from referral to Children's Services if a case is allocated
LAC	Looked after children
Multi-agency	Both statutory and non-statutory agencies working together