

Families that have alcohol and
mental health problems:
A template for partnership working



Social Care Institute for Excellence
Better knowledge for better practice

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Contents



	Page
Acknowledgements	1
Introduction	4
Values and principles	7
Getting started	9
Devising a protocol	11
A universal protocol	12
Examples from practice	13
1. Give instructions and requirements	13
2. Be authoritative	16
3. Link to legislation, policy and procedures	17
4. Be easy to use	20
5. Help people to think and act differently	25
Using the protocol	27
References	30

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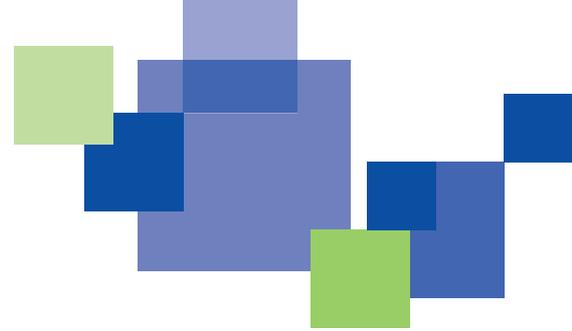
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Introduction

This report is about delivering high quality co-ordinated services to families where children live with parents who misuse alcohol or have mental health problems. In line with government policy, it recognises that promoting the well-being of children and keeping them safe should be achieved, wherever possible, by providing support for parents in bringing up their children and by ensuring that children do not take on excessive or inappropriate caring roles in their family.

It promotes the use of collaborative protocols to further good practice and offers a template for agencies to use when developing local initiatives. This report was commissioned by the Department of Health, initially from the National Institute for Social Work (NISW), and then from the Social Care Institute for Excellence (SCIE). It complements the work undertaken by the Joseph Rowntree Foundation in *Supporting disabled adults in their parenting role* (Wates, 2002).

Balancing the rights and needs of both the children and adults in these families can pose difficult dilemmas. All parents want to do their best and those with alcohol and mental health problems are at times acutely aware of the effect of their illness or alcohol misuse on their children. They may be reluctant to ask for help, as they fear that their children may be removed. Most children in this situation also fear being removed. As a result, they do not readily share their problems with the services that may

alleviate them. The legislation relating to services and the rapidly changing organisational arrangements within and across services may exacerbate this difficulty. There are many different routes into services and no single service can currently meet all families' needs.

Why protocols are useful

The team's first report *Working with families: alcohol, drug and mental health problems* (Kearney, Levin & Rosen, 2000) noted the usefulness of joint protocols that set down the collaborative arrangements between agencies. Feedback from agencies suggests that protocols are doubly useful, as the collaboration required to produce them is also a model for good working practices in applying them. Therefore, a protocol for collaborative working should:

- be the result of agencies working together to produce it while reaching a common understanding of roles, values and actions;
- reinforce and set out the steps to be taken in order to work together in joint assessment, care planning, management of risk, monitoring and reviewing in individual cases.

The team recommends that agencies create a universal protocol that is applicable to all agency settings and to all parents who make contact with services. Supplementary information pertinent to different groups or service agencies can then be included as required. This information could cover

glossaries, definitions and further explanation of unfamiliar legislation. One supplement, for example, might be 'Information for Parents'. This format emphasises the commonality of work across agencies and of parental needs. Examples of this format are detailed later in the report.

Protocols and their limitations

These tools are a necessary part of the agency repertoire and a lever towards clear, consistent and competent practice. However, they are not sufficient conditions in themselves to ensure that families get reliable help. Above all, they are not a substitute for expert, confident, well supported practitioners in adult and children's services who are able to reflect on and critically appraise an individual situation and make sound, knowledge-based decisions alongside service users.

Thus, in reviewing practice when things go wrong, it is not acceptable to maintain that, "we followed the procedure", or "we were only following orders", or even that "we had the procedures in place but they were not implemented". This work is complex and demanding and it is important that all the practitioners involved are trained, skilled and have the organisational support and structures in place to facilitate co-ordinated working and good processes and outcomes for families.

The protocols that have been examined are variable in scope, length, content and quality. The team chose examples from a range of protocols to illustrate the examples set out in the template. The team attaches high importance to the processes following the production of the protocol, for example,

implementation; dissemination; maintenance; monitoring; review; updating and evaluation. Evaluation of outcomes, particularly from the families' point of view, is crucial.

Why a template is useful

The team's first report noted the value of the template approach within drugs services. This has the advantage of the Standing Conference on Drug Abuse (SCODA) guidelines on which to build local arrangements. This second report looks specifically at how useful this approach might be for mental health and alcohol services.

The definition of a template in this report is a pattern, model or design that can be used as a guide in developing services and that can be adapted and tailored to suit local conditions. It draws on the experiences of those agencies that supplied the team with documents and gave an account of how these were developed. This report focuses on mental health and alcohol services, although many of the key principles and processes would apply to all adult services, including drugs. This report offers a template for developing better, more family-centred approaches to working with families where there are alcohol and mental health problems.

The team has based the template on the policies, protocols and procedures provided by social services and Area Child Protection Committees (ACPCs) following the team's request to all Councils with Social Services Responsibilities (CSSRs) in England. This was followed up by discussions with named contacts and visits to selected social services departments to further explore practice development and

implementation issues. These exercises have enabled the team to examine over 70 written policies, protocols and guides and to develop a template that may be useful to the decreasing but nonetheless substantial number of authorities who do not have protocols in place or are in the process of developing them. The template may also be helpful to agencies by providing a benchmark for reviewing their existing procedures and their frontline practices and seeking to improve them.

Using a template to create a local protocol

Some of the agencies that responded had adapted protocols they saw working well in other agencies. The authorities that have developed inter-agency policies and protocols reported that an enormous amount of work and time is involved in producing them, getting them agreed and getting them “owned” and used within and across agencies and teams. Several social services departments and ACPCs that had recently issued joint working protocols had not started from scratch. Instead they had contacted departments that already had written policy and practice guides in place. This approach saves time but it is essential that key stakeholders are fully involved in the local process. This means that the process and the protocols are not simply imported and imposed.

Special mention should be given to two joint service initiatives that have been particularly influential in this way.

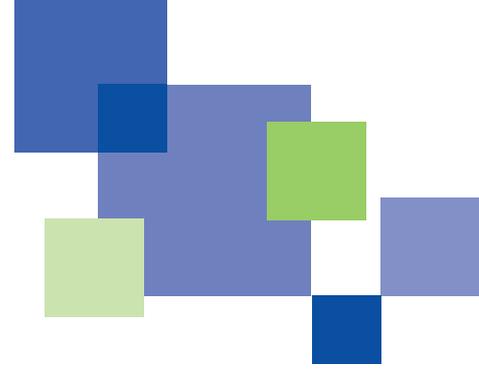
- Camden Social Services with Camden and Islington Community Services NHS Trust and the Royal Free Hampstead NHS Trust have produced joint service protocols for families

affected by mental illness and with drug and alcohol misusing parents. These documents are formally acknowledged as a source by a number of other protocols.

- In Oxfordshire, the *Oxfordshire Interagency Policy for Parents with Disabilities, Sensory Impairment, Illness, Addiction and/or Mental Health Difficulties* has been influential in promoting user participation and the inclusive concept of disabled parents as the basis for services.

These experiences suggest that it is important for agencies to each have their own arrangements in place for working with families and with other agencies and professionals. These can then form the basis for collaborative processes in this area of work.

Values and principles



Collaborative working in services for children where parents have mental health or alcohol problems draws on several developments in social care, which are briefly discussed below.

- The knowledge base informing those offering assistance to children and families and protecting children is now greater than ever. Improved treatments for severe mental illness can mean fewer side effects, an important benefit for parents caring for children.
- Parenting is a complicated task and is influenced by characteristics in the parent, the child and the environment. Precisely at what point parents need help or things start to go wrong is not always obvious except with hindsight. Research shows that many families struggle for a long time with a high level of need before approaching social services.
- There is more awareness of the needs of disabled parents. Parents with mental health and alcohol problems have needs in common with other disabled parents. The links between the responsibility to keep children safe and to provide services to families to help with parenting are currently much debated.
- There is a growing recognition of the needs, tasks and roles of children and young people with disabled parents. This involves how best to protect these children from taking excessive

or inappropriate care of their parents and ensuring their own well-being and development. This includes providing timely and appropriate services to parents to support their parenting roles.

- There is a need for agencies to work together and a concern about how to achieve this. Many services are being re-organised into separate care groups. Workers often focus on either the adults or the children and feel inexperienced when moving outside their perceived remit.

In summary, the team found some key principles that underpin the template protocol. The welfare of children is always paramount. They must always be protected from actual or likely significant harm. All workers, including those who provide services for adults, have a duty of care and responsibility to identify children who may be at risk and to act appropriately. Parents want to do their best to care for their children. It is government policy to promote the well-being of children through timely and appropriate support.

Confidentiality

Workers from all agencies, including those who work with adults, have a responsibility to identify individuals with mental health and alcohol problems who are parents. They should consult with parents about the help and services they need to enable them to care for their children. Any areas of concern and the involvement of children and families

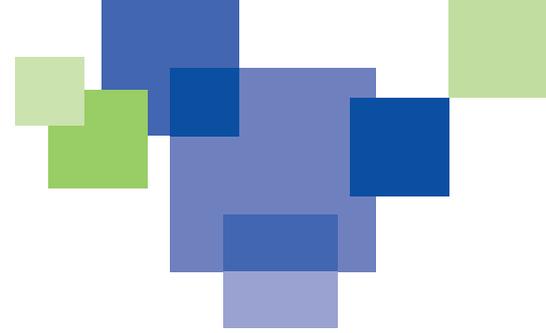
services should be discussed fully with the parents, providing that this does not compromise the safety of the child.

Lack of consensus about information sharing and confidentiality still inhibits collaboration between professionals, agencies and families. Authoritative guidance is given in:

Working Together to Safeguard Children (1999) paragraphs 7.27 to 7.46.

Framework for the Assessment of Children in Need (2000) paragraphs 346-357.

Getting started



Protocols are the recording of an agreed way of acting, to achieve an agreed purpose. How that agreement comes about, and who makes it, are essential pre-requisites to successful working. The protocols have often been the end result of much hidden work. Details of this are set out below because hidden work is easily forgotten. These processes are the building blocks for successful protocols.

Identify need and desired outcomes

At the very start, it will help to set down what you want to achieve and how you will measure your success in achieving it. You may find that you modify this over time and in collaboration, but clearly stated objectives at this stage will aid joint working. Shared understanding and agreement about the key principles that are outlined in this report will be helpful at this early stage.

Identify key players

You should decide which agencies, and which individuals from within them, to involve, as well as the purpose of this involvement. The map of key players can be complicated, and agencies may consider what is the smallest, most effective group to bring together, either as a first stage, or as an agreed, designated group to take the work forward.

How to involve service users and their supporters

Service users and their supporters belong to the key players group. However, the team noted that service users and

supporters were rarely involved in developing the protocols. The team noted that when service users led the work, the quality and content of the protocol was of a different order. The team would argue that service user participation is an essential part of this work, although it may be the area where agencies have the least skill and experience.

Identify relevant legislation and accompanying guidance

There is major legislation and national guidance concerning children and families, mental health, disability and carers, including a growing number of National Service Frameworks. Government expects agencies and professionals at local level to draw up and agree their own more detailed applications conforming to law and guidance. Local protocols must reference national legislation and guidance and be integrated into existing local policy and practice.

As national material is often issued as “stand alone” documents, local implementation will need to build in joint working arrangements with awareness of the range of legislation and guidance involved. This will inevitably mean working with a wider range of law and guidance than usual for all those involved.

Identify what is already in place and what still needs integrating

All agencies will already have some overarching policy and protocols, for example, in child protection. The interface

protocol should define all the areas in which these policies should operate.

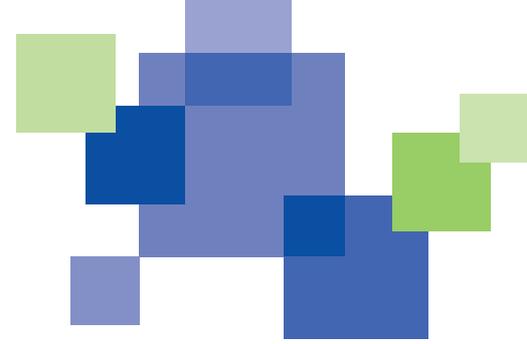
Identify any gaps in working together

This level of collaboration should build on existing arrangements for working together, such as referral systems between services, shared data bases and systems to identify families in need of integrated services. If these are not in place, they will need to be created.

These preliminary steps will help to agree a shared work plan:

- fill any identified gaps in working together;
- ensure service user participation;
- connect to the national and local policy map;
- connect to any existing protocols;
- explore and gain a workable consensus on:
 - ◆ values and principles
 - ◆ vocabulary
 - ◆ definitions of key concepts (for example, confidentiality, disabled parents, young carers)
 - ◆ boundaries of responsibility for agencies and individuals
 - ◆ agree the standards that the protocol aims to sustain, including its relationship to national performance management agendas for health and social care and locally agreed performance indicators.

Devising a protocol



A protocol is the message that the organisation gives to its practitioners about *what* to do and *why* to do it, that is, the organisation's values and policy statements, and *how* to do it, that is, its practice guidance and implementation processes. A protocol brings together a competent organisation and capable workers.

The previous section has outlined the 'chain' along which a protocol is brought into practice. This section draws on the material supplied by health and social care agencies. The team noted some common characteristics, usually arrived at by separate, local development, and gives examples. It also noted some individual features that seem to strengthen a protocol or provide solutions to some of the problems that others have encountered. Many of these characteristics are the logical result of discovering and following the processes outlined in the previous section.

A protocol aims to give unambiguous, common instruction and guidance to workers in specific situations. It is most useful when these:

- are outside the everyday experience of the worker;
- involve them in areas of practice or with colleagues who they do not normally work with;
- require swift but careful action;
- challenge a worker's custom and practice and/or the operational definitions that they are used to.

Workers in these situations may well feel anxious, de-skilled and uncertain of their facts. A protocol should give enough information and reassurance to act, so that professional skills and judgement come back into play.

So far, this approach fits any practice protocol in health and social care. Working with families where parents have mental health or alcohol problems is an area that would particularly benefit from protocols, especially as workers and service users additionally face a complex series of service interfaces. For parents, these complexities may hinder their access to services. For workers, they may cloud the opportunity to offer family support or to involve other professionals. The core of good practice in working across service and agency boundaries is having shared aims, understanding and language. This may mean finding ways to change habits, attitudes, and services. The best protocols in the sample examined by the team have demonstrated these shifts, so a protocol should also help people to think and act differently. These characteristics can be seen in many of the protocols, although arrived at and expressed in different ways, as the examples show.

During the course of this project the team noted a radical shift in thinking which will in itself, have a major, positive effect on the problems that these protocols aim to solve. For example, both Hampshire's and Bolton's protocols remind their staff of parents' rights and duties, and note the importance of understanding the relationships between child care and child

protection responses. The catalyst for this change in thinking has come from the service user-led definition of “disabled parents”, which includes parents with mental health, drug and alcohol problems. This approach is the basis of both Oxfordshire’s and Northamptonshire’s policy documents. Oxfordshire’s policy document sets out the importance of service users’ participation in its development: “This policy has been informed by practice development in other local authorities; the Social Services Inspectorate report, *A Jigsaw of Services*; Department of Health policy and guidelines; research and experience of families that include disabled/ill parents both nationally and in Oxfordshire.”

There are many ways in which involving parents makes a difference. Parents are well placed to identify what might be the attitudinal, structural, financial and other barriers to using a service. They can help to identify characteristics of a non-stigmatising service and with evaluating new practice. Moreover, they can also advise on the need for accessible information and how to provide it.

A good protocol, therefore, should:

- Give instructions and requirements;
- Be authoritative;
- Be linked to legislation, policy and procedure;
- Be easy to use;
- Help people to think and act differently;
- Have a user-led approach.

Some of these features are interdependent, indeed, the examples in the sample often demonstrate more than one feature.

A universal protocol

The examples in this report suggest strongly that a universal protocol is preferable, with supplementary and specific material about working with drug, alcohol and mental health problems.

This parallels the National Service Framework for Older People with its Single Assessment Process, which is an overarching set of characteristics for local application. One example of this approach is Bournemouth’s protocol, devised by the ACPC and the Drug Action Team (DAT), with explicit expectations of local procedures.

Examples from practice

Practice material is included:

- in a box, when it is a direct quotation;
- as a bullet point, when it is a description of an example;
- as a direct reproduction of material supplied by agencies.

The team is grateful to the agencies that have given permission for their work to be reproduced in this report. These examples illustrate ways of putting ideas into practice. As they all represent work in progress, some of these examples will no longer be current within the agencies as protocol development will have moved on.

1. Give instructions and requirements

Instructions and requirements about role and task tackle the “where does my job end?” anxiety that many workers face. The examples in this section aim to make the unfamiliar more familiar and clarify individual and agency responsibilities.

- Brent’s protocol has an appendix with addresses and contact numbers for all teams and agencies involved in the care of families with drug and or alcohol problems, amounting to 29 in all. While this helpful feature requires updating, it shows staff the range of agencies that are involved and who they can contact for help.

Any assessment of a patient should always take account of whether he or she has children or otherwise has significant contact with children.... Standard questions to be asked of every patient: Do you have any children or have you ever had children? Do you care for/look after or have contact with any children?

County of Nottinghamshire & City of Nottingham ACPCs Mental Health & Child Protection-Practice Guidance for Assessment

Joint working protocol: mental health & child care: All records should show all workers and services involved with any member of a mental health client’s family who is under 18 years old. Children’s records should show the involvement of the mental health services

Hampshire, Portsmouth & Southampton SSDs and relevant Health Trusts

The goal is to determine whether there is the need to refer to Social Services Children’s services team due to child protection concerns, and if not, how the parent can be assisted and supported so that other identified needs in the child can be met. Unless child protection concerns are evident, an assessment can be paced over several contacts with an initial outcome from the assessment being reached normally within a month.

Bournemouth, Dorset, Poole ACPCs and Dorset Drug Action team Inter-agency child protection policy & practice guidance

Some protocols had flow charts giving a quick and useful alternative to text. The example shown is Camden’s joint service

protocol, which has been adopted by a number of agencies.

Camden Joint Service Protocol for Children & Families Affected by Mental Illness

Figure 1: A Model of Referral/Initial Response for Children & Families Affected by Mental Illness.

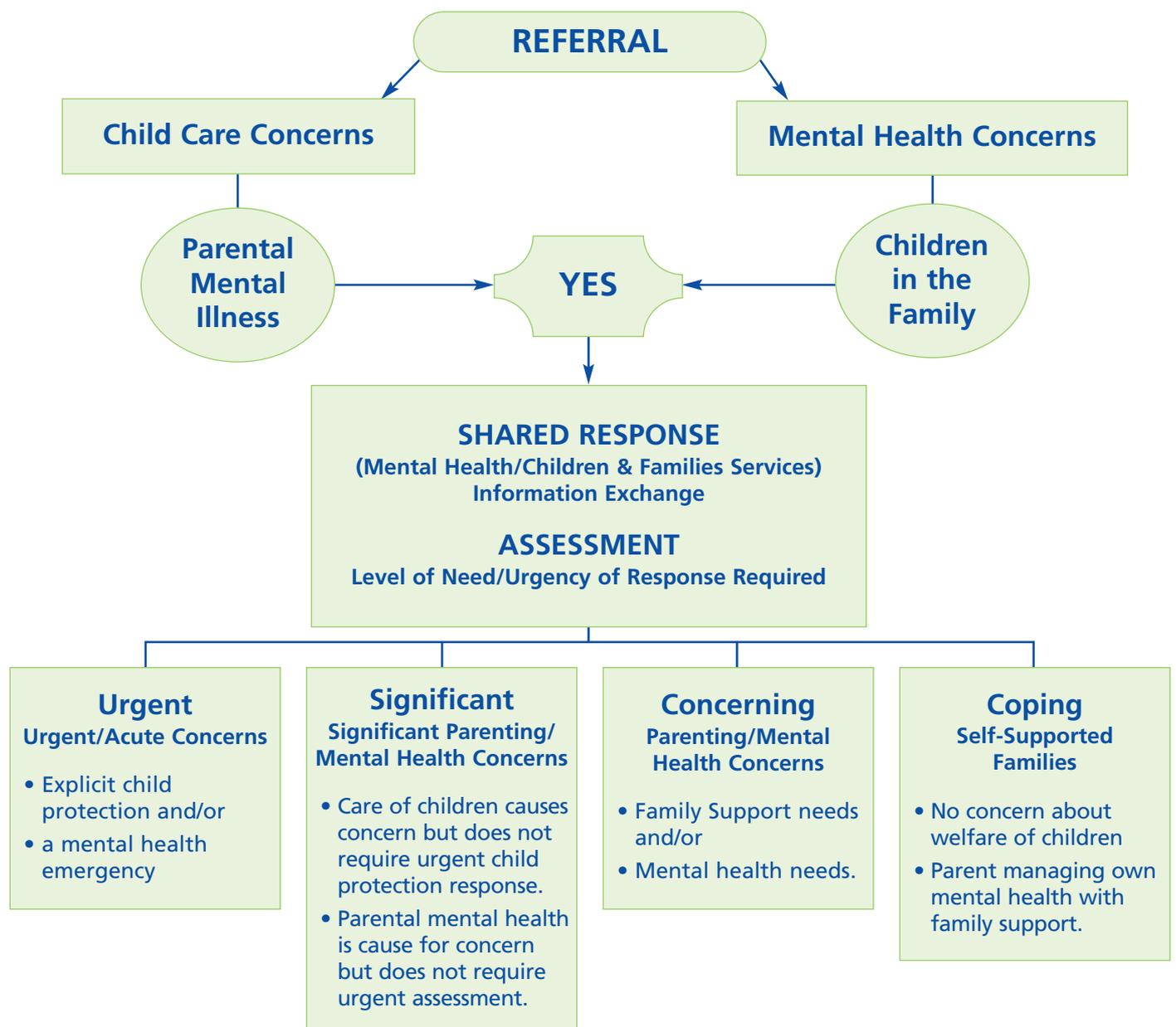


Figure 2: A Model of Assessment and Care Planning for Children & Families Affected by Mental Illness.

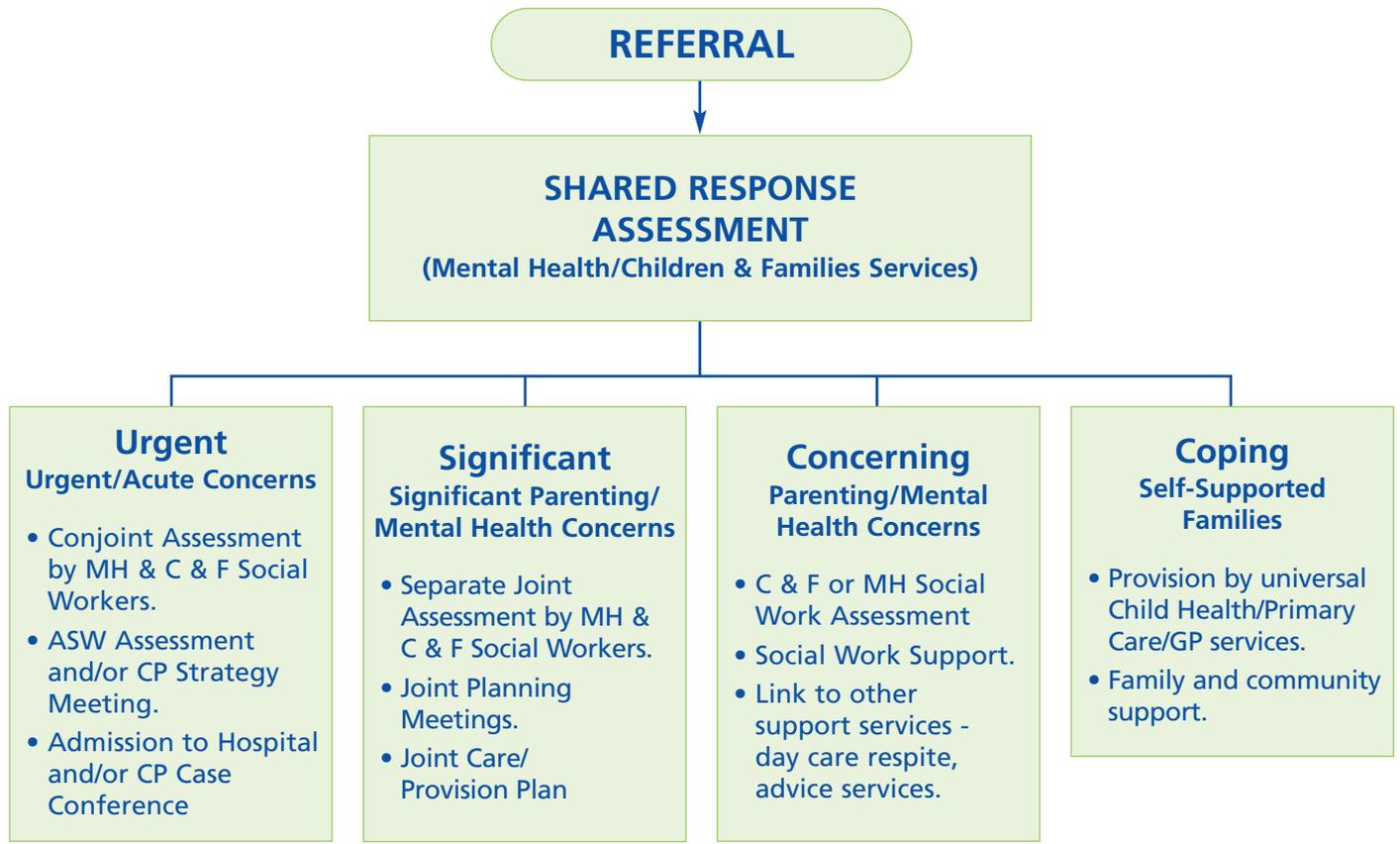


Figure 3: Assessment and Care Planning: Levels of Intervention.

Referral/Assessment Along Continuum of Need	Response/Assessment and Care Planning
Urgent: Acute Concerns: explicit child protection concerns and/or mental health emergency.	Urgent Needs: At the most urgent or severe level of need, there should be a conjoint assessment by both children and families and mental health workers working together closely. Plans should be developed together and reviewed jointly.
Significant: Parenting or Mental health Concerns: care of children causes concern but does not require urgent child protection response and/or parental mental health is cause for concern but does not require urgent assessment.	Significant Needs: Children and families and mental health workers should make separate assessments of need but work together to formulate care plans with the family.
Concerning: issues about Parenting/Mental health: there is a need for support to the family and/or for mental health service support for the parent.	Concerning: Either children or families or mental health services could assess needs and provide support either family support services (such as day care) and/or supportive mental health services (such as counselling).
Coping: Self-Supported Families. There is no concern about the welfare of children and parent is managing own mental health with family and primary care support.	Coping: These are parents with mental health problems who are able to function adequately and to care appropriately supported by universal and primary care services as well as family.

2. Be authoritative

All workers need to know where the authority for these instructions and requirements comes from. This is where organisational clarity supports individual behaviour. Examples include:

- Dorset mental health services give their protocol the status of a management circular, which is a “must do” document.
- South Yorkshire Child Protection Committees’ Procedures opening page sets out the status of the document in some detail.
- Nottingham gives its documents authority by including the signatures of all the relevant chief executives, namely the Director of Nottinghamshire County Social Services, the Chief Executives of North Notts. Health Authority, Central Notts. Health Care Trust, Nottingham Health Care Trust, the Director of Nottingham City Social Services, and the Chief Executives of Nottingham Health Authority, Bassetlaw Health and Community Services NHS Trust, and Rampton Hospital.

This is especially important when asking staff to work across agency and service boundaries, demonstrating to staff that their own agency endorses and has helped create the protocol. The team noted that not all the protocols had been developed solely, if at all by ACPCs. Some agencies noted that this had not been the most productive way forward, and instead had located it within Trusts or other agencies when it was thought that ownership by these agencies was more likely to be achieved if they led the work. The partnerships that worked were sometimes a second or third attempt.

Examples include:

- Bournemouth: a joint initiative by the ACPC and the DAT.
- Bolton: a Mental Health/Child Protection initiative through the ACPC.
- Hampshire’s protocol was developed by relevant commissioning managers across the Social Service Department (SSD) and Mental Health Trusts (MHTs).
- Hartlepool’s work was led by the local DAT.
- Peterborough worked through the MHT/SSD.
- Avon and Wiltshire Mental Health Partnership Trust has produced a multi-agency document *See the Adult, See the Child*. This is agreed by Swindon Housing and Social Services Department, Wiltshire and Swindon Health Care NHS Trust “plus other agencies as agreed”.

Some protocols have a values statement about interface working:

- Surrey’s Mental Health, Child Care and Child Protection services have developed a protocol specifically for links and communication across the various services.

All organisations within Brent will treat parents and pregnant women who use drugs and/or alcohol in the same way as any other parents who require their support and services. All organisations have a duty to safeguard and promote the welfare of children in Brent.

Guidelines for inter-agency working in the London Borough of Brent front page policy statement

East and West Surrey Health Authorities and Surrey Social Services have agreed this protocol and expect all Trusts providing Mental health services to follow it.

Surrey SSD & East and West Surrey Health Authorities Adult Mental health & Child care/protection

3. Link to legislation, policy and procedures

Collaborative working must take account of the law and any related guidance and must be linked to local policies, protocols and procedures. Agencies that collaborated from an early stage recognised the importance of doing this explicitly. This helps staff who may be better versed in some areas than others. It reminds them of the wider picture and how this specific area of practice is in fact a local implementation of the expectations of various pieces of legislation and policy. These include: *The Children Act 1989, The Mental Health Act 1983, The NHS and Community Care Act 1990, The Human Rights Act 1998, Working Together to Safeguard Children (1999), The Framework for the Assessment of Children in Need and their Families (2000), the National Service Framework for Mental Health (2000) and Fair Access to Care Services (2002).*

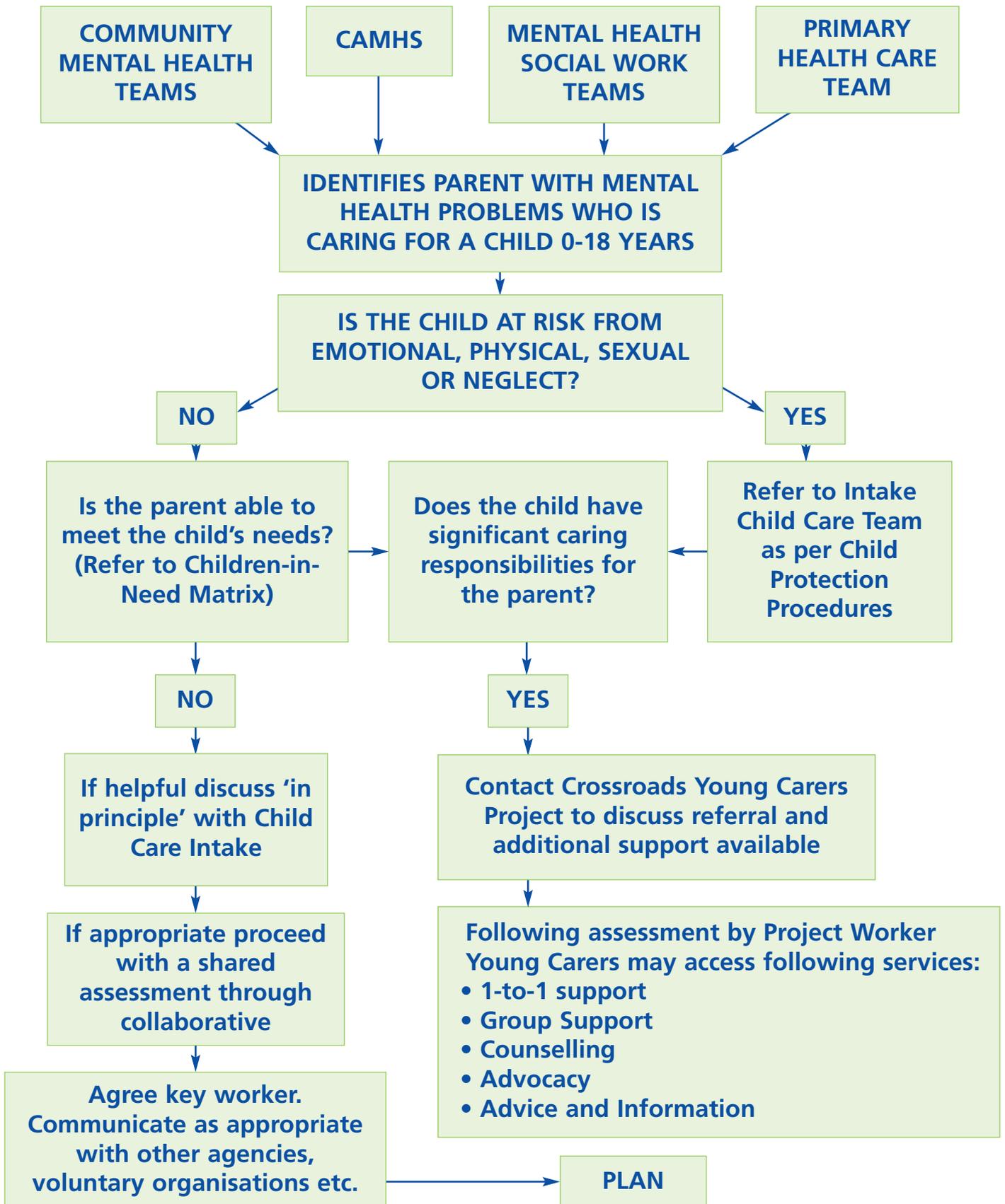
Some agencies achieved this by locating specific guidance or protocols within the existing child protection (CP) documents, protocols or manuals. Examples of these include:

- Redcar;
- Leeds;
- South Yorkshire ACPC;
- Redbridge.

Other agencies produced discrete protocols for working with families across drug, alcohol and mental health services. These make more sense to workers and parents when they are linked to mainstream policies and procedures. Examples include:

- Surrey's protocol has a legal table setting out the wider statutory context within which it operates;
- Stockton on Tees reminds staff that "a protocol is a risk management tool", putting a family-focused procedure into context for adult mental health workers;
- North Somerset's *Practice and Procedure Guidelines for Children whose Parents have Mental Health Problems* are located within a flow chart for child protection, child in need and family support action - see example.

Children Whose Parents Have Mental Health Problems Flowchart



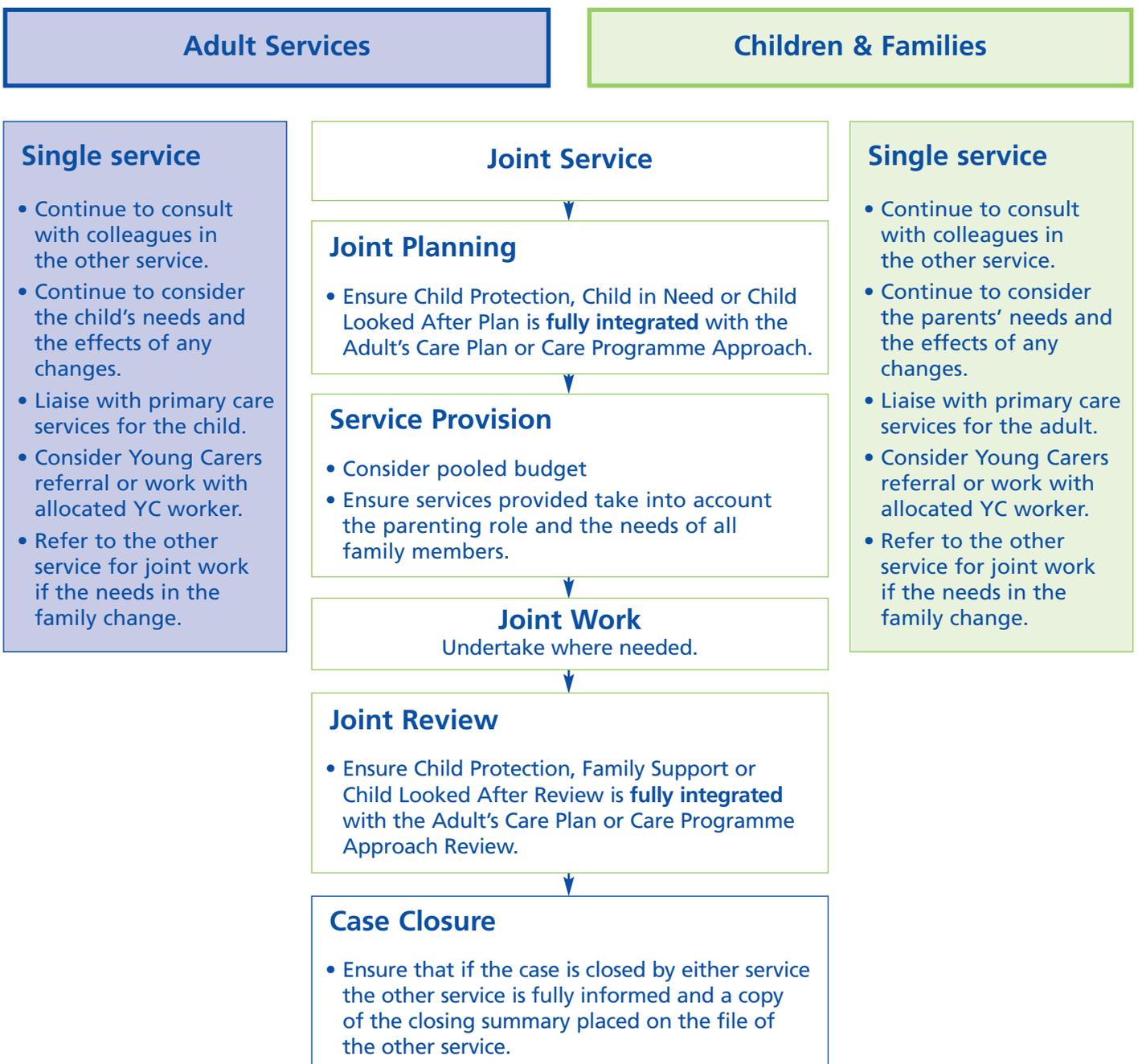
Some protocols were the result of new approaches to collaborative effort.

- Bolton has developed a *Child Concern Handbook* for all agencies working with children. This gives an overarching collaborative approach within which work with parents who have mental health, drug and alcohol problems can fit.

- Hillingdon mental health workers are given a number of indicators to guide them in their decision about whether an initial screening assessment for parenting and child related issues is needed.

- A flow chart has been designed to accompany the Westminster protocol. See example.

Westminster City Council Adult and Children & Families Services Working Together PLANNING AND REVIEW



This protocol complements but does not replace ACPC procedures...This is an accompanying document to be used with the mental health assessment tool where there are children in the family....This protocol needs to be read in conjunction with your local ACPC Procedures.

Hartlepool Mental Health & Child Protection protocol

Monitoring and Training

Where significant risk involving the other service is identified, this will be recorded on mental health risk assessment forms or child protection section 47 enquiry forms. The responsibility for the compliance of the use of these forms rests with supervisors/team managers. Any difficulties with their use must be brought to the attention of the respective Service Manager. The Mental Health Service Manager and the Children's Service Manager (Fieldwork) will ensure that the actions taken are appropriate, and will monitor any issues at the six-weekly monitoring meetings.

Wokingham District Council, Community Services Department protocol

4. Be easy to use

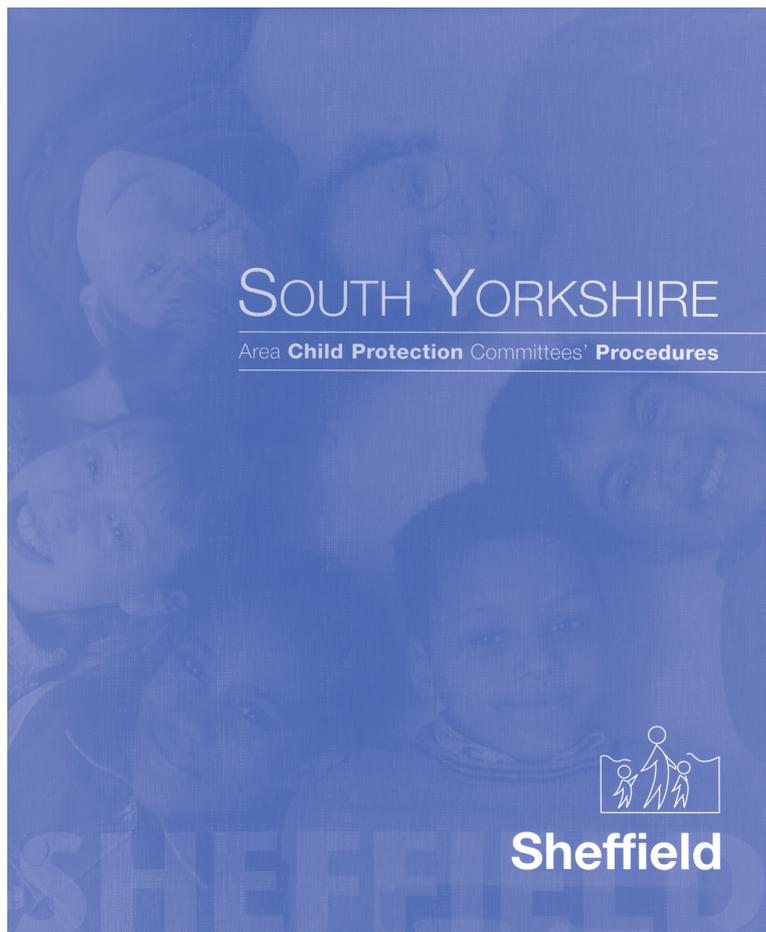
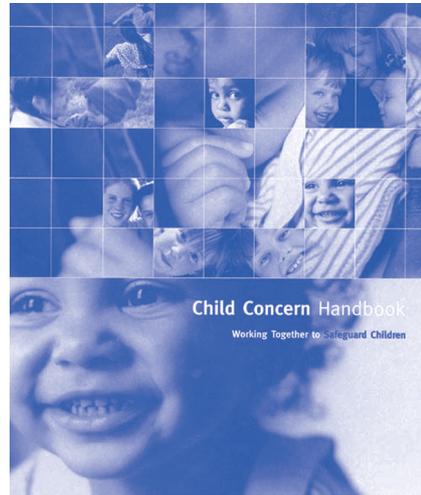
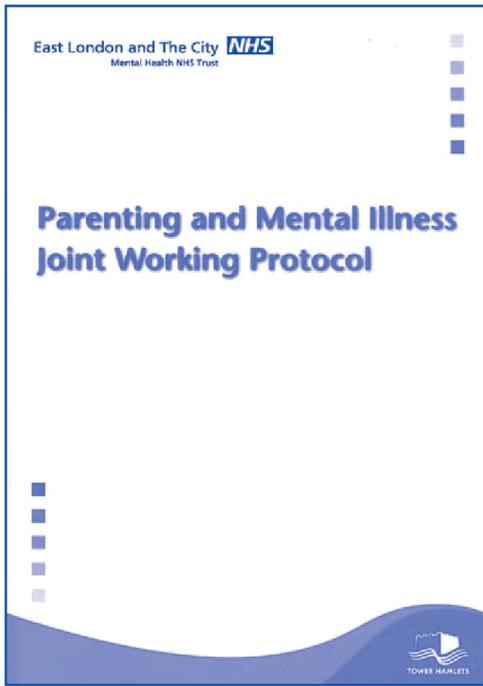
The team noted a number of other specific features that are likely to encourage effective take-up.

Design

The sample produced four examples of good design, which are reproduced in this report as they were easy to understand, easy to navigate and looked as authoritative and confident as their contents proved to be. All have a high quality of production and printing. Good design comes at a price but these examples show the benefits this brings. Each example looks very different, underlining the importance of local adaptations of universal requirements. Front covers are reproduced from the following protocols to show the impact of high quality design and production:

- South Yorkshire ACPC;
- Bolton;
- Tower Hamlets.

Protocols from East Sussex are reproduced in full as an example of design and layout aiding clarity, brevity and ease of use.



Specific Circumstances Parents/Carers with Mental Health Problems

Child factors

- Child acting as “young carer” for the parent
- No alternative or substitute care
- Impact on child’s growth, development, behaviour and/or mental/physical health including alcohol/substance misuse and self-harming behaviour etc.

Threshold

The majority of parents who suffer mental ill-health are able to care for and safeguard their child(ren). Child Protection Procedures will be needed when:-

- the parent/carer needs adversely affect their capacity to safely parent the child.
- there is insufficient alternative care for the child within the (extended) family to prevent emotional abuse (including emotional support for the child), neglect, or other incidents of abuse.

The thresholds for these forms of abuse are explained under the relevant headings, e.g. neglect involves assessment of persistence, repetition, severity and the parents’ own emotional strengths and weaknesses.

Response

Responding to child protection concerns where parents have mental health problems requires mutual responsibility by both Adults and Children’s Divisions. This focuses attention on the adult mental health/child protection interface.

“One of the main risks to children whose parents have mental health problems is the failure of adult psychiatric services and child protection agencies to understand each other and communicate adequately” (Falkov 1995)

The concerns about communication raised by Falkov focussed on particular stages in the interface; the information gathering stage; the conferencing process and the monitoring arrangements.

Some professionals working in mental health services may not recognise the suffering of children whose parents are mentally ill as abuse or neglect.

All health practitioners and clinicians must consider the needs of the child(ren) and make effort to find out about the welfare and safety of the child via other family members, primary care services (e.g. health visitor, school nurse, GP, school staff) and/or secondary or specialist services (e.g. Social Services, CAMHs etc.)

When a child is deemed to have suffered or likely to suffer significant harm, or there are detrimental effects on the health or development of a child, a referral must be made to the Children and Families Division. A decision will be made if immediate action is required, or an initial assessment undertaken, to be discussed at a strategy meeting.

2.

East Sussex Area Child Protection Committee

Specific Circumstances Parents/Carers with Mental Health Problems

The strategy meeting will then decide whether the threshold has been met for: -

- S.47 enquiries, a core assessment, a S.47 Child Protection Conference, *or*
- a core assessment to be discussed at a S.17 child-in-need meeting, *or*
- services for a vulnerable child.

Working at the interface between services for adults and children and families requires particular attention to be paid to the following: -

- The complexity of the systems interface and the inclusion of professionals working within each part of the system (see diagram The Systems Interface)
- Working in partnership strategies across agencies and services that facilitate and emphasise the need for clear understandings and effective communications.
- The importance of providing the opportunity for Adult Services staff to discuss concerns with Children and Families social work staff.
- Integrated assessment models.

Clarity of purpose

In the examples sent to the team, terms such as 'guidance', 'procedure' and 'protocol' were sometimes used for documents that could not function as a protocol. Where protocols were described as agency practice guidance, this seemed to dilute their status. Some documents and handbooks clearly listed their contents and separated instructions from supporting material. These appeared easier and clearer to use in practice environments. See illustration of Westminster's protocol.

Collaboratively written protocols are likely to benefit from a range of different styles of practice. For example, the team noted that those protocols that had a health input, were more likely to include questions to prompt readers as well as clear instructions.

Protocols that were developed and written collaboratively did not assume that all staff would be familiar with all of the legal frameworks or assessment processes in this complex area of practice. This enables staff to feel competent about their own area of practice and understand better the practice concerns of other disciplines. For example, the Westminster protocol takes the worker through the relevant legislation, summarising its application to this type of work.

Adults and Children's Services Working Together Protocol

This protocol sets out the Social and Community Services Department's response to families where parents, carers or other adult family members experience specific needs or difficulties requiring support or services in their own right, which may also impact on the well being of their dependent children. The policy has been agreed with Central and North West London Mental Health Trust.

1. Service principles
 2. Legal framework
 3. Information sharing, consent and confidentiality
 4. Referrals and thresholds for services
 5. Working together in assessment and planning
 6. Assessing young carers
 7. Management oversight, decision making and supervision
 8. Professional development
 9. Structure Charts and Key Contacts
- Westminster City Council

Credibility

Some protocols acknowledged other areas of professional anxiety and the realities of daily practice. They anticipated and articulated problems and offered solutions.

- Peterborough's protocol recognises that workers in adult mental health services may be less used to considering family support issues. It understands that differences of opinion will arise and includes designated arbitrators. It gives a list of factors to consider when talking to parents who have mental health difficulties.
- Bolton's *Child Concern Handbook* is a resource for the very wide range of staff who will come into contact with children.
- Brent's protocol is careful not to assume specialist knowledge of the area of work and gives staff a named contact within other services. This style of protocol needs to be updated regularly but offers concrete solutions to what are often unacknowledged and disempowering circumstances for staff.

Child protection procedures are stressful and can exacerbate mental health problems, which may suggest even higher risk than otherwise. Any assessment and intervention should, therefore, be handled with special sensitivity, keeping a low key supportive approach as far as possible.

Surrey SSD

5. Help people to think and act differently

An effective protocol will also need to help with some of the other barriers that may have made interface working difficult. Examples are taken from SSDs unless otherwise stated.

- Hillingdon's protocol specifically includes working with families who do not meet the agency's child protection threshold.
- Stockton on Tees includes a confidentiality statement within the protocol.
- Northamptonshire's protocol demonstrates how to include families who do not meet service eligibility criteria.

The team noted some significant individual features that were particularly helpful to staff and address key issues, often setting out new ways of working.

- Several protocols address the practicalities of joint care planning and funding care packages.
 - ◆ Barking and Dagenham's protocol states the need to have mechanisms in place to make integrated care plans.
 - ◆ Northampton's protocol includes a section on financial issues, acknowledging that some families will cross the usual departmental boundaries. Financial negotiation should take place away from the family and cost sharing should be considered.
 - ◆ Southwark's protocol formalises joint responsibilities and sharing of costs giving clear guidance on

allocating funding and managing the care package.

- ◆ Westminster's protocol gives clear instructions for budget arrangements at case closure, any service transfer arrangements and other service change.
- South Yorkshire ACPC says that in supervision sessions, mental health staff must identify parents on their caseloads and consider the children's needs using *The Framework for the Assessment of Children in Need and their Families* (2000). Staff who are not involved in children and families services should be able to consult children's advisers or the Child Protection Adviser in their workplace.
- Southwark's protocol says that community mental health teams should carry out systematic assessments of children in families where the adult has a mental illness. They should consider the needs of the parents resulting from their parenting responsibilities as well as their mental illness. They should work with or refer to children and family teams as appropriate.
- Hillingdon's protocol says that mental health workers should check on service users' parenting responsibilities, and describes the referral process to children and families services.
- Hampshire's protocol has "parenting capacity assessment hints" for mental health workers.
- Wokingham's protocol states there should be clear lines of responsibility and the need to consider the whole family – "think family".
- Oxfordshire's inter-agency policy covers eligibility criteria that include an adult's entitlement to receive support in their parenting role whether or not their child meets the criteria of a "child in need." It also addresses the issue of continuing to give appropriate support to parents when there are child protection concerns.
- Some protocols, notably Northamptonshire's and Oxfordshire's, adopt an inclusive approach to the parenting needs of all those who, for whatever reason, are disabled or ill. Northamptonshire's protocol "includes all parents with physical illness and disability, including learning disability, dependency and addictions, and difficulties relating to personality disorder or mental health." The protocol supports the right of disabled people to fulfil their role and responsibilities as parents, as well as the right of children to live in a safe environment, which meets their needs.
- Oxfordshire takes a similar approach, because "parents encounter more barriers to participation than their non-disabled peers, and as parents are more likely to be affected by inflexibility in service provision," and states that: "Assessment of the disabled/ill parent(s) should identify the support and assistance needed to enable parents to meet their parenting responsibilities."



Using the Protocol

Getting it on the desk

Staff with key responsibility for organisational protocols often told the team that they had not given sufficient attention, time, planning and financial resources to the dissemination of protocols. One social services manager described the production of a protocol as being: "Quite a feat in itself. One draws a deep breath and then realises that there is another stage . . . dissemination and implementation."

Some departments appeared to measure the success of their protocols by how many hundreds of copies they had distributed. The widespread distribution across and within departments is vital but it does not automatically follow that they will be read, understood and put into practice. Having a sufficient budget for the production of many copies is necessary but there also needs to be a clear strategy for making sure protocols actually get to staff and that they know about them. Having a copy "available" is not going to work on its own.

Training staff about new protocols is important but it is not the only way to ensure that they understand and "own" protocols. Often too high an expectation is placed on training as the main vehicle for the dissemination and implementation processes. Ownership and use by managers is at least as important.

A variety of mechanisms needs to be in place to make sure the dissemination and implementation of a protocol is carried out. The following are crucial: availability; training; public launches and

publicity; discussions in team meetings; inclusion in induction for new staff; and regular reference to them in supervision.

If service users have been involved in compiling the protocols, they can be instrumental in implementation. Service user knowledge about agreed protocols can be very powerful in getting them into practice and in making them relevant and practical on a day to day basis. Protocols should be made as available as possible to service users.

The team was struck by the lack of attention paid to the issue of non-compliance with protocols and how this might affect practice. The consequences of non-compliance in terms of the effect on families, and any sanctions on the employee are not spelled out.

Protocols must make sense to busy staff and family members who may be distressed and anxious. Documents and instructions that are long, difficult to read or hard to follow will not be implemented. Protocols must point the way to best practice. Their main purpose is not to act as a defensive protection for staff or the organisation, although effective protocols should guard against poor practice for both service user and service provider.

Getting it right

Protocols, especially those that contain factual information, must be kept up to date. Most organisations still need to upgrade and improve their maintenance activities for protocols. The production and use of protocols is a dynamic process.

However, monitoring and maintenance are generally viewed as less exciting and creative than devising a protocol.

The production of useful and “owned” protocols can be a time consuming and expensive process. Adapting protocols from those who have already carried out much of the basic work can speed up the process, but such protocols have to be made applicable to local circumstances, the efficiencies gained must not be at the expense of local collaborative processes.

Costings need to take into account the continued need for maintenance. Protocols need to be designed so that they can be adapted for the changes that continually occur in practice, policy and the law.

Keeping it relevant

Services are likely to continue to change and gaps in policy, practice and underpinning protocols are continually being identified. It is essential, therefore, that senior managers and practitioners set aside time for the regular review of practice.

At the heart of evaluation there must be a focus on service users. The involvement of service users and front line staff is crucial. This includes evaluating whether individual children, their families and carers get the support they want and need. For everyone involved systems are needed to ensure that service interventions are appropriate. This requires systems that identify users of adult services who are parents as well as the number of families in children’s services that have parents with mental health and alcohol problems. A performance indicator that identifies the

number of disabled parents, including those with mental health or alcohol problems known to services, would aid this development

Local service audits and reviews commonly include an appraisal of the information available about the service. This can cover a wide range including: service specific information; operational policies; procedures and practice guidance; service user participation; accessibility assessment; service availability; staffing and strategies for joint staff development; examples of good practice; the quality of care and planning issues. The audit appraisal can ask whether there are written operational policies and practice protocols; who these are for and how and where they are made available. It can ask about how these were compiled, how often and by whom they are reviewed, and how the most current versions are distributed.

None of the examples of protocols in the sample had been produced with information aimed at families, although this should be possible, and should be required. Service user involvement might have ensured this by:

- helping to define the needs, outcomes and tasks for protocol content;
- receiving accessible versions of the protocol detailing what to expect – both as an entitlement to information but also as a lever for accountability, action and compliance;
- participating in monitoring and evaluation.

Evaluation should cover both the processes and outcomes of services, for

individual families and all user groups across the spectrum of services. This becomes increasingly complex as services diverge and new interfaces emerge between children and families services and the new care trusts, with multi-disciplinary services for adult mental health and alcohol services.

Above all, remember:

- protocols by themselves will not guarantee good practice. They are one tool in the box, not the only one;
- social care is a complex occupation and agencies must provide protocols to help staff and families and must ensure that staff use them. Protocols are not an optional extra but part of good practice;
- agencies must not wait for serious situations, such as the death of a child, to develop protocols;
- protocols can seem like control from elsewhere, written by people who do not have day-to-day responsibility for the work. However, the regular routine use of well designed protocols that staff have helped to develop will give them a better sense of control over their work;
- issues of power and autonomy will be keenly felt by the users of these services, and as with frontline staff, their involvement in standard setting and the development and evaluation of policy and protocol will help resolve some of these issues.

References

Department of Health, Department for Education and Employment, Home Office (1999) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*, London: The Stationery Office.

Department of Health, Department for Education and Employment, Home Office (2000) *Framework for the Assessment of Children in Need and their Families*, London: Department of Health.

Falkov, A (ed) (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children. Reader - for managers, practitioners and trainers*, London: Department of Health.

Local Government Drug Forum and Standing Conference on Drug Abuse (1997) *Drug using parents. Policy guidelines for interagency working*, London: Local Government Association.

Mayes, K, Diggins, M and Falkov, A (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children. Trainer*, London: Department of Health.

Robinson, W and Dunne, M (1999) *Alcohol Child Care and Parenting. A handbook for practitioners*, London: NSPCC London.

Wates, M (2002) *Supporting disabled adults in their parenting role*, York: Joseph Rowntree Foundation.

We would like to thank the following organisations, and their local partners, for permission to cite their work in this document. The agencies noted usually represent a consortium of local effort between health, housing and non-statutory agencies and demonstrates the range of collaborative partnerships that we have seen.

Bolton Area Child Protection Committee

Bournemouth Borough Council

Brent London Borough Council

London Borough of Camden
Social Services Department

Dorset County Council
Social Services Department

East Sussex Area Child
Protection Committee

Hampshire County Council
Social Services Department

Hartlepool Borough Council
Social Services Department

London Borough of Hillingdon
Social Services Department

Leeds City Council

Northamptonshire County Council
Social Care and Health

North Somerset Council
Housing and Social Services

Northumberland County Council

Nottingham City Area
Child Protection Committee

Oxfordshire Social Services Department

Peterborough Social Services Department

Redbridge London Borough Council
Children and Families Service

Redcar and Cleveland Borough Council
Social Services Department

South Yorkshire Area
Child Protection Committee

Southwark London Borough Council
Social Services Department

Stockton on Tees Borough Council
Social Services Department

Surrey County Council Social
Services Department

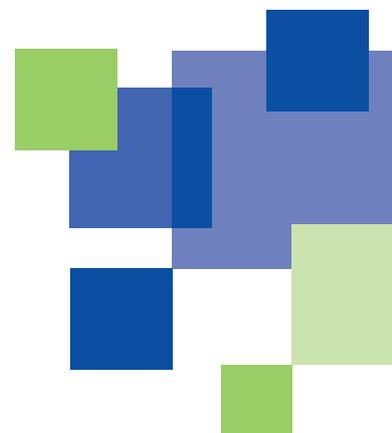
Swindon Borough Housing and
Social Services Department

Tower Hamlets London Borough Council
Social Services Department

Westminster City Council
Social and Community Services

Wokingham District Council
Community Services Department

Welsh, Braille, tape, large print and easy read versions of this paper can be made available on request.





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