

Joint Services Protocol to meet the needs of children and unborn children whose Parents or Carers have Mental Health Problems



**Merton
Safeguarding
Adults Board**

Merton Safeguarding Children Board

Merton Safeguarding Adults Board

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Foreword

This protocol is important for the safeguarding of children and families in Merton. It should be read and implemented when necessary by staff who deliver services to children and young people whose parents or carers have mental health problems, and staff who deliver services to adults who are parents or carers with mental health problems. The protocol applies equally to pregnant women and their partners where there are concerns about their mental health. The protocol also applies to adults with mental health problems who have contact with a child or children, even if they are not a parent or carer; for example, siblings, lodgers, family visitor, babysitter or childminder.

This document was drafted jointly by Merton Safeguarding Children Board and Merton Safeguarding Adults Children Board, which includes the Clinical Commissioning Group, South West London and St Georges Mental Health Trust.

Research and local experience have shown that mental health problems in parents/carers or pregnant women can have a significant impact on parenting and increase risk, especially for babies and younger children. This does not mean that parents who experience mental health problems are poor parents. However, the impact of mental health problems can, on some occasions, lead to children and families needing additional support; or in a small number of cases support and multi-disciplinary action to prevent significant harm.

The Merton Safeguarding Children Board (MSCB) and the Merton Safeguarding Adult Board (MSAB) are committed to ensuring early help and that intervention is provided to enable and support parents including those with mental health problems to care safely for their children.

To achieve this, the protocol promotes good multi agency working including appropriate information sharing, joint assessment of need through the use of the Merton Wellbeing Child, Young Person and Family Well-Being Model and making effective use of Team Around the Family (TAF), for those parents with mental health problems, who are in need of additional help in caring for children and young people.

This work should be underpinned by working in partnership with parents and children and applying a 'Think Family' approach.

In the minority of situations, where parents are unable to care safely for their children, the protocol will ensure that there is effective joint working between adult and children and young people's services, so that risks to children can be assessed and appropriate support is provided to meet assessed needs and/or prevent significant harm.

Evidence tells us that children are more at risk of experiencing neglect when the parent or carer has significant mental health problems; co-ordinated understanding, planning and service delivery is vital to children's wellbeing, as neglect can fluctuate both in level and duration. Key to delivery is timely and decisive action. It is important that professionals recognise the long term, developmental consequences

of neglect on a child and the need for the urgency of early intervention to prevent the impact of neglect.

The MSCB and the MSAB expect all agencies working with children or adults, who are parents in Merton, to implement this protocol and to ensure that all relevant members of staff are aware of it and know how to use it.

Keith Makin
Independent Chair MSCB

Teresa Bell,
Independent Chair MSAB

1. Introduction

Being a parent with a mental health problem can be particularly challenging. Many parents are painfully aware that their mental health problem can affect their children even if they do not fully understand the complexities.

All children, even very young children, are sensitive to the environment around them and so their parent's state of mind has an impact on them. In this context, all children are vulnerable when a significant adult in their lives has a mental health problem. For example, in some cases children and young people themselves can be identified as being young carers who are entitled to an assessment under the Care Act 2014.

Children in such families can be vulnerable depending on the severity and impact of their parent's mental health and because of secondary factors such as, low income; poor housing and neighbourhood; stressed family relationships and societal prejudice. Parents with mental health problems need to be encouraged and enabled to discuss their concerns without fear of prejudice.

Likewise, their children have a right to have their needs assessed, receive appropriate services and be heard in their own right so that risk factors can be minimised and protective factors promoted. In this way, children will be enabled to achieve their potential and move confidently into adult life.

All the agencies in Merton are committed to early intervention to ensure that all children and young people, including those whose parents have mental health problems, are protected and enabled to achieve their full potential.

As many of the children of parents with mental health problems are likely to require additional support from agencies across the spectrum of universal, targeted and specialist services, this protocol focuses on the identification of these needs at an early stage.

This protocol sets out:

- Key questions that all practitioners working with adults who have mental health problems must ask in their work, where their patients or service users are parents, parents-to-be or are in contact with children
- Clear guidance about the pathway to obtaining additional support for the children or young people who need early help or safeguarding
- Guidance for the children's workforce about when to access additional support for the adults who are experiencing mental health problems

Safeguarding adults is everyone's business.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having

regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances (taken from Care Act 2014 guidance).

A parent with mental health issues may be deemed an adult at risk by the Care Act 2014 definition:

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

If you need to report a safeguarding concern, please ensure you gain the person's consent and if there is a need to override consent, there must be a public or vital interest, or the adult is deemed to lack capacity to give their consent.

This protocol accepts the guidance as supplied in the London Multi-Agency Safeguarding Adults Policy and Procedures. Please refer to the Merton Intranet Safeguarding Adult's page for details of how to raise a safeguarding concern.

2. Aims of the protocol

- I. To ensure that professionals working in Merton are clearly aware of their duty to work together to safeguard and promote the welfare of children.
- II. To improve the identification of children who may be affected by adult mental health problems and ensure good quality and early support and intervention for them and their families.
- III. To improve communication and joint working between services responsible for supporting children, and the services responsible for supporting adults experiencing mental health problems.

3. Principles

In line with the Children Act 2004, Children and Families Act 2014 and the current London Child Protection Procedures, all professionals who come into contact with children, their parents and families in their everyday work have a statutory duty to safeguard and promote the welfare of the child (see section 1 Children Act 2004). This applies even if the professional is not a social worker in Children's Social Care or a designated or named safeguarding professional. This is emphasised in Working Together 2018.

Core Principles

- The welfare of the child is of paramount importance

- Parents, carers and pregnant women with mental health problems have the right to be supported in fulfilling their parental roles and responsibilities
- While many parents, carers and pregnant women with mental health problems safeguard their children's well-being, children's life chances may be limited or threatened as a result of those factors which adversely affect the mental health of their parents, and professionals need to consider this possibility for all clients with children
- A multi-agency, joined up, children and adults approach to assessment and service provision is in the best interests of children and their parents and/or carers
- Risk is reduced when information is shared effectively across agencies
- Risks to children are reduced through effective multi-agency and multi-disciplinary working across both children's and adult services
- Services and interventions will be provided in a timely manner and will be based on the assessed needs of the whole family
- The focus should remain on the safety and welfare of the child at all times
- Children's needs are best met when professionals and parents work in collaboration
- We value and appreciate diversity. However, cultural factors neither explain nor condone acts of commission or omission which cause a child to be placed at risk or, be harmed. Anxiety about possible accusations of racist practice should never prevent necessary action being taken to protect a child or vulnerable adult.

4. Identifying the needs of the child, when their parent, carer or expectant mother is experiencing mental health problems

Any professional working in Merton who comes into contact with an adult or pregnant woman with a mental health problem must consider:

- How is their mental health impacting on the safety or welfare of any children in their care, or who have significant contact with him/her
- Whether they have access to the relevant support services
- Whether the child/young person is a young carer.

The birth of any new child changes relationships and brings new pressures to any parent or family. Agencies need to be sensitive and responsive to the changing needs of parents or carers with mental health problems.

Parents, carers or pregnant women with mental health problems may have difficulties which impact on their ability to meet the needs of their children or expected baby. This protocol acknowledges that such children may be in need of assessment for services provided by a range of agencies, from universal and early intervention to specialist services for those with more acute or complex needs.

This set of questions and the two flowcharts are designed to guide your decision making about how you can best meet the needs of children and adults in families experiencing mental health problems:

The following questions should be asked of both men and women:

- Does the person have (or is likely to have) dependent children or close contact with children (e.g. babysitting, after school care, present in the same house hold etc.)?
- What are the child's details - age, name, address, and ethnicity?
- Is there a young carer in the house?
- Is the person or their partner pregnant? If so, has the prospective mother contacted services regarding ante-natal care?
- Is the child registered with a GP?
- Is the child attending school if appropriate?
- Have you seen the child/ren?
- Have you spoken to the child/ren where appropriate?
- Have you considered the impact of your patient or client's mental health on their ability to meet the needs of their children?
- Is your client an expectant father/partner who has mental health problems?
- Do you know what other services are involved and what their role is?
- Do you have any concerns about their children's well-being or safety?
- Are there any alternative care arrangements in place if needed? If so, what are they and who has/is arranging these?
- Is the child/young person at risk of significant harm? If so you should contact Children's Social Care immediately - see 'who to contact' Appendix 1.
- Are there any cultural considerations to take into account for the assessment?

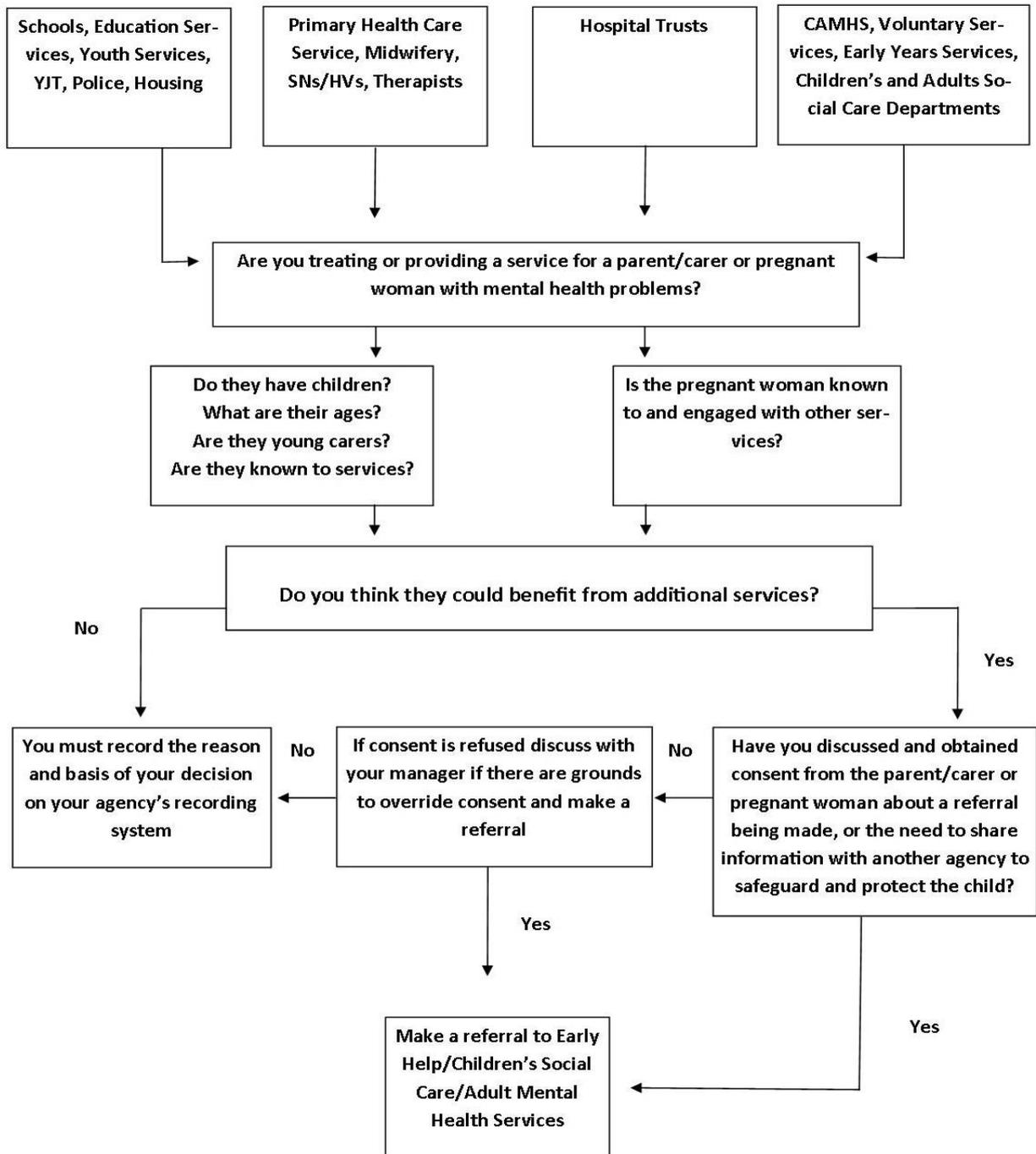
Actions

- Do you think that the family/parent/carers or pregnant woman would benefit from any additional services? For example IAPT or perinatal mental health services
- Can support be provided from within your service/agency?
- Have you discussed the need for any additional services, or making a referral to another service with the parents, carers or pregnant woman (e.g. has the midwife discussed with the mother the range of support that is available)?

- Have you discussed or sought advice from your manager or appropriate safeguarding lead?
- Have you sought consent to make a referral and to share information from the parent/carer?

Professionals should document the above in their appropriate client and/or child records.

Decision-Making Flowchart



5. Guidance for referral and assessment for pregnant women with mental health problems to additional services

All agencies are responsible for identifying pregnant women with mental health problems who may be in need of additional services and support. Pregnant women with a previous history of mental health problems are particularly vulnerable to breakdown during the later stages of pregnancy and following the birth of their baby. Needs should be assessed and support offered as early as possible.

When an agency identifies a pregnant woman who is experiencing mental health problems, an assessment should be considered to determine what services she may require. This should include gathering, with consent, relevant information from the GP, Adult Mental Health Services and Children's Social Services and any other agencies involved, to ensure that the full background is obtained about any existing or previous diagnosis, or treatment for mental illness. Consent should be sought however consideration should be given to overriding this if the level of risk determines that information sharing is required. This is especially important where service awareness of earlier births may need to be clarified, particularly from social care in the case of previous children or those not born in the UK.

Where the need for referral is unclear this must be discussed with a line manager or professional adviser and/or safeguarding lead/advisor before referring to the appropriate services. If a referral is not made this must be clearly documented with the rationale. Staff must ensure that all decisions and the agreed course of action are signed and dated.

Where this assessment identifies that a pregnant woman has mental health problems and there are significant concerns a pre-birth assessment by Children's Social Care (CSC) should be undertaken. Guidance on pre-birth assessments is provided in the current London Child Protection Procedures.¹

The outcome of the CSC pre-birth assessment will determine whether there are sufficient concerns to warrant a pre-birth child protection conference.

A pre-birth assessment may be undertaken and a professional's strategy meeting held where:

- There has been a previously unexplained death of a child whilst in the care of either parent
- There are concerns about domestic violence
- A family member or partner is a person identified as presenting a risk to children
- A sibling/child in the household is the subject of a child protection plan
- A sibling/child has previously been removed from the household either temporarily or by court order

¹ London Child Protection Procedures, Core Procedures, Part A, section 2.6.
http://www.londoncp.co.uk/chapters/referral_assess.html

- The degree of parental substance misuse in itself or combined with mental illness is likely to significantly impact on the baby's safety or development
- The degree of parental mental illness/impairment is likely to significantly impact on the baby's safety or development. This includes mental illness where a baby or unborn is the subject of abnormal or unusual ideas or attributions
- There are concerns about parental ability to self-care and/or to care for the child (e.g. unsupported young person or a mother who has a learning disability)
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricating or inducing illness in a child.

6. **Guidance for referral to Mental Health Services²**

When there are concerns that the parent or carer is exhibiting signs of mental illness, and they are not known to mental health services, a decision should be made about whether a referral should be made to the Merton mental health services.

Referrers should consider if a referral to the local IAPT service would be the appropriate service in the first instance.

Improving Access to Psychological Therapies (IAPT)

Cricket Green Medical Practice, 75-79 Miles Road, Mitcham, Surrey CR4 3DA

Tel: 0203 823 9063

Email: mertoniapt@addaction.org.uk

For referrals: MERCCEG.mipt@nhs.net

A referral for an initial assessment to mental health services should always be made if there is a statement or behaviour from a client that raises concerns or indicates a risk to self or others, including children. As far as possible these concerns should be discussed with the client unless it increases the risk to the child, parent or professional. A referral should always be discussed with your line manager. Advice can be sought from the mental health services and or the designated/lead Safeguarding professionals.

Merton Assessment Team;

To make a referral enquiry 0203 458 5596

Email: ssg-tr.mertonassessment@nhs.net

² See also London Child Protection Procedures, Part B: Practice Guidance, Chapter 30: Parenting Capacity and Mental Illness, http://www.londoncp.co.uk/chapters/par_cap_ment_illness.html

You need to provide the person's details (including ethnicity, gender, spoken language, etc.) and the GP's details including the NHS number if you have it and any background information. Please describe what you are worried about and confirm that the adult has agreed to the referral. If the person has not agreed to the referral, this must be noted along with a clear rationale for why consent has been overridden. The client's unwillingness to agree to a referral should lead to a reassessment of the level of risk; however, every effort must be made to ensure that the client fully understands the concerns and reasons for the referral.

Contact with the GP and Merton mental health services is essential to ensure that the full background is obtained regarding any existing or previous diagnosis of mental illness and information about previous or current treatment to aid your decision-making regarding any further input from mental health services.

If there is an immediate danger to the client or others, including a child, the police must be contacted.

Staff must ensure that their decision and agreed course of action is fully and accurately documented, signed and dated.

Triggers that may indicate the need for a referral to Adult Mental Health Services for an initial assessment are listed below. However, this is not an exhaustive list and is provided to assist professional decision-making. It should be noted that mental health problems can also be associated with high risk behaviour or difficulties such as substance misuse

- Previous or current history of assessment and treatment by secondary mental health services, including hospitalisation or previous Community Mental Health Team involvement
- Previous or current treatment for mental health problems by a GP
- Previous history of overdose or self-harm and especially if there has been more than one such episode, or current expression of an inability to manage their own or their child/children's safety
- Expression of apparently unreal fears about their own safety or that of others
- Evidence of significant withdrawal from people, family or activities i.e. showing signs of depression or anxiety
- Fluctuations in mood and activity e.g. excessive crying, inappropriate expression of anger, over activity, or increased suspicion
- Concerns regarding self-neglect
- A child's or other's expression of concern regarding change in the parent's and/or carer's behaviour or attitude
- Evidence of personality factors (pre-existing and/or exacerbated by the illness e.g. irritability, hostility, inability to cope, self-preoccupation, etc.)
- A previous history of severe childhood trauma and adversity, including discontinuities in carers and experience of abuse where this may be impacting on the person's current mental state
- A history of violence (as a perpetrator or a victim) with unstable, discordant parental relationships

- Environmental stressors outweighing support and protective factors, for example; poor-quality support and social isolation in association with multiple adversities such as discrimination (on grounds of gender, ethnic minority status sexuality and mental illness), material deprivation and poverty
- Concerns regarding adult learning capacity
- Expressions of delusions incorporating their children and/or where a child or unborn is the subject of an unusual idea or attribution (See Parental Mental Illness of the London Child Protection Procedures)
- Significant concerns regarding adults with possible eating disorders.
- Non/poor/chaotic engagement by parent or carer
- Obsessive compulsive rituals by parent or carer
- Significant trauma as an adult that is impinging on their ability to manage routine activity

7. What to do if you are concerned that a child is at risk of significant harm and needs to be protected

Where there is imminent risk to the child in an emergency, the Police should be called.

Where children are considered to be at risk of significant harm they should be immediately referred to Children's Social Care (CSC) by telephone and the referral should then be followed up in writing within one working day.

Following referral, Adult Services and CSC should, where appropriate, undertake joint visits and joint assessments to assess the level of risk to children, consulting with other agencies if involved with the family.

Adult mental health professionals must be included in any strategy meetings convened by CSC and CSC included in any Care Programme Approach or other mental health planning meetings where the adult's needs are assessed to ensure that consideration is given to the needs of the child.

Assessment and identification of parent's, carer's or children's need for services is not a static process. The assessment should build in evaluation of progress and effectiveness of any intervention. Agencies should always take into account the changing needs of adults and children. Regular dates should be set to jointly review the situation and ensure that interagency work continues to be coordinated.

These services should endeavour to work in partnership with parents and children, obtaining consent for joint working. Information sharing consent should be sought in the first instance.

Children should be invited to contribute to the assessment as they often have good insight into the patterns and manifestations of their parent's mental health. This is a key learning point coming out the Child B Serious Case Review 2017.³

³ Please see the Child B SCR Report http://www2.merton.gov.uk/mscb_scr_child_b.pdf

Services should always be flexible and ready to reassess or review cases speedily before planned reviews if new concerns or support needs arise.

If the concerns about the parent/carer's mental health are not significant but there is a cause for concern, a referral to the person's GP or other primary care services such as primary care psychology should be considered.

Each agency should document their own actions and responsibilities clearly as well as the roles and responsibilities of other agencies. Where appropriate copies of Child in Need or Child Protection plans should be obtained and stored confidentially on the individual agency record.

Please refer to the London Child Protection Procedures
http://www.londoncp.co.uk/chapters/responding_concerns.html

8. Identifying children in need of protection or who are at risk of significant harm

Any of the following parental risk factors justify immediate referral to Children's Social Care for an Assessment (or Strategy Meeting depending on the urgency and severity) to determine whether a child has suffered or is at risk of suffering significant harm.

This list is not exhaustive:

- Where the child features within parental/patient delusions or is involved in the parent's delusions or is involved in the parent's obsessional compulsive behaviours
- Where the child is a target for parental/patient aggression or rejection
- Where the child may witness disturbing behaviour arising from mental illness (e.g. self-harm, suicide, uninhibited behaviour, violence, homicide)
- Where a child is neglected physically and/or emotionally by an unwell parent/carer
- Where a child does not live with a parent with a mental health problem but has contact (e.g. formal unsupervised contact sessions or the parent sees the child in visits to the home or on overnight stays)
- Where a child is at risk of severe injury, profound neglect or death
- Where parents are prone to altered states of parental consciousness e.g. splitting/dissociation, misuse of drugs, alcohol, and medication
- Where parents are showing non-compliance with treatment, reluctance or difficulty in engaging with necessary services and lack of insight into illness or impact on the child
- Where parents have mental health problems combined with criminal offending (forensic)
- Where the parent has a disorder designated 'untreatable' either totally or within timescales compatible with the child's best interests
- Where the pre-birth assessment of women who have a history of mental illness, or who are experiencing a mental disorder, suggests that there are concerns about the impact of such conditions on an unborn child, or a woman's ability to meet the child's needs once born

- Where there are parents or carers who are exhibiting signs of mental illness, or who are already the subject of a continued psychiatric assessment, where there are concerns surrounding the impact on a child's wellbeing
- Where there are concerns about domestic abuse
- Where a family member or partner is a person identified as presenting a risk to children
- Where there are children who have been the subject of previous child protection investigations, a child protection plan, local authority care or alternative care arrangements
- Where there have been previous consecutive referrals to CSC concerning parents, carers and their children
- Where there are urgent concerns as a result of parents or carers being assessed under the Mental Health Act
- Where there are parents or carers with significant mental health problems who are struggling to care for a child with a chronic illness, disability, or special educational needs
- Where there are children who are caring for parents or carer with mental health problems (please see the London Child Protection practice guidance regarding young carers)⁴
- Where there are children with significant social, educational or health needs e.g. non-attendance at school or nursery, lack of involvement with other statutory or primary care services
- Where information shared between agencies highlights concerns about the well-being of a child please see Information Sharing Protocol: Appendix 2.

9. Referral to Children's Services

Merton has developed an approach to Early Intervention. The focus is on identifying and meeting needs for children, young people and families earlier and more effectively. A fundamental component of early intervention is defining what help is needed which is why high quality assessment is so significant. The strategy highlights our local commitment to developing a common approach to the understanding and recording of the needs of children, young people and families from the earliest point of identification. It is our intention that effectively targeting help at these stages will reduce reliance on specialist services and enable children, young people and families to become as independent as possible in identifying and addressing any concerns that arise in family life.

How do I complete the Referral?

Enquiries should be made when your assessment has identified needs which can only be met through enhanced services at amber (complex/statutory) or red (acute/specialist/statutory) tier of the Merton Wellbeing Model.

The Merton Wellbeing Model can be found at www.merton.gov.uk/mwbm.htm

⁴ http://www.londoncp.co.uk/chapters/young_carers.html , Chapter 14, London Child Protection Procedures, Part B: Practice Guidance, Young Carers

You can talk about your decision with social care professionals based in the MASH and any decision reached should be clearly recorded by the agencies involved.

Before making a MASH enquiry

Before making a MASH enquiry you need to consider if the child or young person's needs can be met by services from within your own agency or by other professionals already involved with the family.

We know that it is sometimes difficult to decide the appropriate point of intervention. To help you to determine levels of need when making your own assessment please refer to the multi-agency additional needs descriptors at:

www.merton.gov.uk/mwbm-additional-needs-indicators

You can always contact the MASH team for advice on completion of the Child Protection Referral Form or the Common and Shared Assessment (CASA)

Before making an enquiry you should always get the consent of the parents or carers except where a child is considered to be at risk of harm and you believe that seeking parental consent may increase this risk.

What should I do if I identify a safeguarding concern?

Urgent referrals relating to Child Protection:

If you believe that urgent action is needed because, for example, a child is in immediate danger or needs to be accommodated by the local authority (red - acute/specialist/statutory - level of the Merton Wellbeing Model), phone the MASH on 020 8545 4226 or 020 8545 4227 (Out of hours: 020 8770 5000).

Your call will be passed immediately to the manager who will make a decision on the risk level and acknowledge this with you within one hour. You must follow up your telephone call by sending a completed Child Protection Referral form to the MASH within 24 hours.

Other Child Protection concerns

If you have a Child Protection concern and urgent action is not needed (amber - complex/statutory - level of the Merton Wellbeing Model), you must complete a Child Protection Referral form in as much detail as possible and send it to the MASH at mash@merton.gov.uk.

All other concerns

For any other concerns, or where a CASA is already in process, you should complete a CASA form, providing as much up-to-date detail as possible. Whichever form is used it should be shared with the parent or carer and, where appropriate, with the child, prior to making the enquiry. The information you provide will support threshold decisions and contribute to any subsequent assessments, such as a Single Assessment.

The early help assessment and Child Protection Referral forms are found at

www.merton.gov.uk/mash/mash-refer.htm.

After the MASH process

Once a fuller picture about the case has been established the MASH manager will decide on the most appropriate decision to take.

This may mean passing it to the First Response team along with the information gathered by the navigators or referring the case to an Enhanced or Specialist service.

Where the MASH manager decides that the case does not require an Enhanced or Specialist service but that the family may benefit from some identified lower-level support, the family will be offered signposting to an appropriate Universal Service.

If there is no wellbeing or safeguarding issue and the family does not need any additional support, then the case can be closed and no further action will be taken.

Referrers and professionals will be notified in writing regarding the outcome of the referral.

It is essential that the identifying details (e.g., names, dates of birth, etc.) are accurate and complete as this will ensure that if additional services are required they are directed at the right child, young person or family. A good quality referral should provide a clear link between the reason for a request for services and/or support and the information itself.

A critical component of the referral is exploring which factors in the parenting and family and environment dimensions are impacting on the development of the child or young person. For example, indicating that the parent is 'anxious' or 'depressed' and not including any information regarding the impact of this on the child does not always help other services understand the kinds of concerns that a practitioner may or may not have.

As a minimum, practitioners must clarify why the referral is being made and should include the risk and needs of children or young people who have been identified.

Consent

It should be possible in most cases to obtain the consent to make a referral and it is important that practitioners highlight the benefits. In particular, the more relevant, accurate and up-to-date information that is shared with other practitioners the more likely it is that they do not need to tell their story repeatedly and that their child's needs will be met quicker and more effectively. If adequate information cannot be shared then children may be subjected to more assessments and this takes people away from being able to deliver the help required.

The parent/carer should understand that any information that is shared will be treated with the utmost confidentiality and they as parents can, subject to some caveats, place limits on the sharing.

http://intranet/mash_leaflet.pdf

Data Sharing and Fair Processing

Section 10 of the Children Act 2004 places a duty on key people and bodies to cooperate to improve the wellbeing of children and young people. This includes the proportionate sharing of information, where appropriate, to make the best decisions for children and young people at risk.

The Government Guidance in Working Together sets out the safeguarding children processes to be followed by all practitioners.

10. Conflict resolution and escalation

Research and Serious Case Reviews have shown that difference of opinion between agencies can lead to conflict resulting in less favourable outcomes for the child. If disagreement remains between agencies every effort should be made to reach satisfactory resolution under the guidance provided in the London Child Protection Procedures and the MSCB's Escalation Procedure (https://www2.merton.gov.uk/mscb_escalation_procedure_june_2016.pdf).

Where a professional requires advice and guidance on child protection matters they should first discuss this with their line manager and/or their designated lead professional for child protection. If further clarification and guidance is required they can seek this from the MASH.

If agreement cannot be reached on action required following discussion between first line managers (who have sought advice from their designated/named/lead officer/child protection advisor), then the matter must be referred without delay through the line management to the equivalent of service manager/detective inspector/head teacher and or designated professional.

In Merton, it is agreed that where conflict and disagreement still remains (following the above process being followed) the matter must be referred to the CSC Quality Assurance and Practice Development Head of Service for final resolution.

Tel: 0208 545 3191

Records of discussions and any decisions must be maintained by all agencies involved.

11. Training

Safeguarding is everyone's responsibility. All staff are responsible for ensuring their training in child protection is up to date and meets the requirements for their role and job description.

MSCB offers a high quality, comprehensive multi-agency training programme, which includes training on parental mental health. All agencies are required to support their staff's access to child protection training. The MSCB Training Programme may be accessed via the MSCB Webpages (<https://www2.merton.gov.uk/health-social-care/children-family-health-social-care/safeguardingchildren/lscb/lscbtraining.htm>)

All Merton staff are invited to access this MSCB training once agreed as part of the staff member's professional development plan.

Appendix 1: Who to contact

If you are concerned about a child you must always do something. If you're not sure – seek advice

If you think a child is in immediate danger, call the police by dialling 999. If you want to report a crime against a child contact the police through either the local station or 111

To make a referral to Children's Social Care

Urgent referrals relating to Child Protection

If you believe that urgent action is needed because, for example, a child is being harmed or at risk of harm or needs to be accommodated by the local authority (amber or red tier of need in the Merton Wellbeing Model, see appendix), phone the MASH on **020 8545 4226** or **020 8545 4227** (Out of hours: **020 8770 5000**).

If your agency does not have its own guidance or Designated Safeguarding Lead contact Children's Services

Designated Professionals and Advisers in child protection/safeguarding:

Designated Nurse Tel: 0208 812 6724

Education Inclusion Manager Tel: 0208 545 3546

Adults and Volunteers in a position of trust

LADO (Local Authority Designated Officer) Tel: 020 8545 3179

Mental Health

Contact Centre Tel: 020 3513 5000

Support Tel: 0800 028 8000

IAPT

Tel: 020 3823 9063

E-mail: mertoniapt@addaction.org.uk

Website: Merton Mental Health Service

Police

If you need to report an emergency, serious incident, or if you are concerned about immediate safety of a child and young person Telephone: 999 in emergency or 101 in all other cases.

For information on the Multi Agency Risk Assessment Conference (MARAC) contact the Community Safety and Enforcement division please email:

mertonmarac@merton.gov.uk.cjism.net

Appendix 2: Useful Information for adult service users

The first point of contact should be your local GP, who will be able to offer advice and treatment. Your GP will assess you and will refer you to the Community Mental Health Team (CMHT) if you require further treatment or longer term support.

If you have no GP, you can contact the CMHT directly for an appointment.

Community Mental Health Teams (CMHTs)

Your local CMHT can provide information, and advice, or arrange services to help people to live in their own homes and to remain part of the community. There are rules and eligibility criteria determining who receives help from the CMHTs.

- South West London and St George's Mental Health NHS trust
- Merton Older People's Community Mental Health Team (NHS website)

Emergencies

- Your local GP
- Crisis Line - South West London and St George's Mental Health NHS Trust
- NHS direct - 0845 4647 (24 hours)
- Local Hospital Accident and Emergency Department
- Tel: 0800 028 8000

For further information on parental health and its impact on children, please go to:
<http://www.scie.org.uk/publications/elearning/parentalmentalhealthandfamilies/index.asp>

Rethink Mental Illness:

<http://www.rethink.org/>

Royal College of Psychiatrists:

<http://www.rcpsych.ac.uk/>

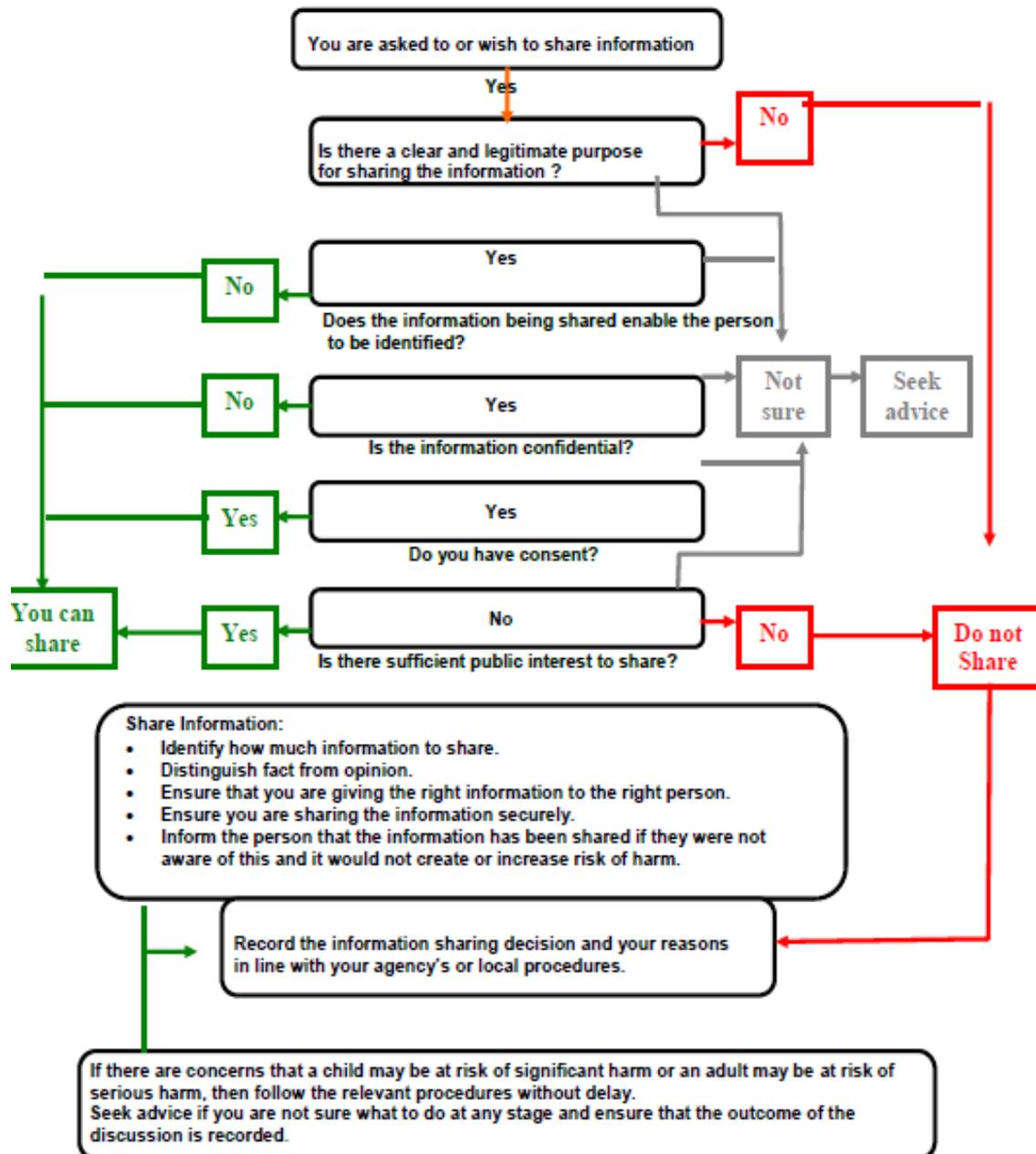
For further information regarding children's legislative framework:

Children Act 2004:

<http://www.legislation.gov.uk/ukpga/2004/31/contents>

Appendix 3: Sharing Information about children or adults

Flowchart of key questions for information sharing



Good information sharing is a crucial element of successful interagency working, allowing professionals to carry out their statutory obligations and make informed decisions based on accurate and up-to-date information, thus improving outcomes for clients. These guidelines are based on local and national guidance

It is essential for all services to accurately record the names, dates of birth, involvement of other agencies and areas of concern for all children in families known to them. If parents, carers or pregnant women decline to provide basic information about themselves or their families this fact should be recorded and, if necessary, advice sought.

Legal framework

As a general rule, personal information that agencies hold on a client is subject to a duty of confidentiality and cannot be shared with third parties. However, information can be disclosed where it is lawful to do so.

Sharing of information is lawful where:

- The client has consented to disclosure
- The public interest in safeguarding a child's welfare overrides the need to keep information confidential
- Disclosure is required under a court order or other legal obligation

Disclosure with consent

Individuals can give their consent to personal information about them being disclosed to third parties but it must be explained why this information is needed and who it will be disclosed to. If the information is sensitive in nature, for example relating to a person's mental health, such consent would need to be in writing and placed on their case file. Verbal consent should be recorded in the case notes.

A young person aged 16 years or over is capable of giving consent on their own behalf; children under 16 years can only give consent if it is thought that they fully understand the issue and are able to make an informed decision. If not, the decision must be made by the person that holds parental responsibility for them. Where an adult, 16 or over, is deemed incapable of giving consent to disclose because they lack mental capacity, consent should be sought, where possible, from a person who has legal authority to act on that person's behalf.

If it is not possible to obtain consent to disclosure, information can be disclosed without consent under the circumstances listed.

Disclosure without consent

Where consent has not been given, or it is thought that to seek consent from a parent or carer may place the child at further risk, professionals should consider whether it is lawful for them to disclose the information without consent.

Clearly, it would be lawful to disclose information in order to safeguard a child's welfare, but professionals must consider the proportionality of disclosure against non-disclosure: is the duty of confidentiality overridden by the need to safeguard the

child? Where information is disclosed, it should only be relevant information and only disclosed to those professionals that need to know.

Professionals should consider the purpose of disclosure and remind those with whom information is shared that it is only to be used for that specified purpose and should otherwise remain confidential.

Further guidance on information sharing with regard to safeguarding children is contained in 'Working together to safeguard children' and in 'What to do if you are worried a child is being abused'. Professionals should also refer to the 'London Child Protection Procedures'.

Guidance about sharing information, including a practitioner guide in relation to children with additional needs, is available from the Department for Education https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf Professionals may also refer any queries on information sharing to their Caldicott Guardian. This is a designated professional who is responsible for implementing information-sharing protocols within their respective organisations and can act in an advisory capacity to help staff share information in a lawful way.

Appendix 4: Mental Health and Parenting Capacity

Mental Health

It is important that all workers should be aware that the term 'mental health problem' covers a range of needs some requiring brief intervention in primary care, while others require referral to specialist mental health services.

Definition

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

Effect on parenting

All parents find parenting challenging at times, and those with a mental health problem often show considerable inner strengths in adequately parenting their child. Being a parent with a mental health problem however, may be particularly challenging. Many parents are painfully aware that their disorder can affect their children even if they do not fully understand the complexities. (Royal College of Psychiatrists 2002, Falkov 1998)

All children even young children are sensitive to the environment around them. Thus their parents' state of mind can have an effect on even the youngest child. In this context, all children are vulnerable when a parent has mental illness but children may be helped considerably where the parent is aware of this. (Stanley et al 2003)

The lack of capacity to parent may well not be the only reason for poor outcomes for children whose parents have mental illness. Factors such as the effects of poor housing, financial difficulties, domestic violence or hostile neighbourhoods may be a significant factor in parental stress and illness. (Stanley et al 2003)

Strengths in the family, such as the ameliorating effects of another adult, can minimise the effects on children of the mental illness of a parent.

Questions about childcare and parenting issues are clearly sensitive and can have important implications for people with mental health problems. The stigma associated with mental illness may make parents reluctant to ask for help, as they fear their child or young person may be removed.

Families may struggle for a long time with a high level of stress, delaying seeking help until a crisis situation; thus leaving little opportunity for preventative intervention. Children in this situation may fear being removed. Balancing the rights and needs of both children and adults in families can pose difficult dilemmas; it is government policy to promote the well-being of children through timely and appropriate support. (Children Act 2004)

Assessment of the impact of these stresses on the child is an important factor in the care plan for the child and the care plan for the parent and reinforces the need to see mental health problems of parents/carers in the context of family life and functioning.

It is essential that an appropriate assessment of the parent/carer's problem is undertaken to understand the impact on any child involved with the family. Children have a right to have their own needs assessed, receive appropriate services and to be heard in their own right so that risk factors can be identified and minimised and protective factors promoted. In this way, children can be enabled to achieve their full potential.

Implications of Mental Health for Parenting

The Royal College of Psychiatrists (2002) states that the link between mental illness and adverse outcomes for children is well established. For parents with mental health needs and difficulties, usually beyond their control, these can create problems in parenting or in being parents they would wish to be.

The failure of any parent to meet a child's basic needs will have an impact on all aspects of that child's health, growth and development.

The Royal College of Psychiatrists (2002) states the effect of parental psychiatric disorder on children's psychological welfare is determined by the social and relational consequences of the parent's disorder. It is the parental behaviour that creates the risk to the children. A parent who is pre-occupied with themselves or emotionally and practically unavailable is more likely to neglect their children's health and well-being whereas a parent suffering from irritability or over-reaction to stress that accompanies anxiety, depression or psychosis may resort to over chastisement or physical abuse of the child.

Where the child becomes incorporated into parents paranoid or threatening delusions, this may pose a significant risk to the child. In their review of 35 child death cases, Reder and Duncan (1999) found that 43% of the parents were suffering from active mental health needs at the time the child died.

Parental personality factors (pre-existing and/or exacerbated by the illness) may mean parents have difficulty controlling their emotions, have an inability to cope or be self-preoccupied. Violent, irrational and withdrawn behaviour can frighten children.

Poor compliance with treatment and problematic relationships with professionals are factors that influence parent's ability to be effective in the care of their children. (Royal College of Psychiatrist 2002)

Unmet mental health problems can lead to the child taking on responsibility beyond their years because of their parent's incapacity. This may include becoming a carer for the parent and/or other children or family members.

The effects of parental mental ill health maybe minimised and ameliorated by a caring adult who is available and cognisant of the fluctuating needs of the parents and can step in to provide a supportive stable environment for the child/young person.

Children may understand when things are not right and if their needs are not being met. They may not be able to, or want to say anything about it, or there may be no-

one to tell; they may just get on with it by taking on inappropriate caring roles for their families.

The needs of the child in his/her own right should be assessed by the children's services social worker within a child care plan which identifies the presence of another significant adult while the needs of the parent should be assessed and addressed by the mental health worker in order to support the parenting role (McDonald 2005 in Taylor & Daniel).

Fear of a child being removed from the parent is considered an obstacle to a parent seeking help for mental health problems.

Children who adapt well to parent's mental illness will at times be:

- Of older age at the time of the onset of parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources)
- More sociable and able to form positive relationships (having an easier temperament)
- Of greater intelligence
- Of a parent who has discreet episodes of mental illness with a good return of skills and abilities between episodes
- Able to access alternative support from adults with whom the child has a positive, trusting relationship
- Successful outside of the home (e.g. at school, in sport).

Royal College of Psychiatrist (2011) Patients as Parents: Addressing the needs, including the safety of children whose parents have mental illness. London: Royal College of Psychiatrist CR164.

Parental and Postnatal Period

Specific concerns apply to the pre- and post-natal periods. It is vital that there is joint working between the General Practice, Midwifery, Health Visiting and if involved,

Specialist Mental Health Services. It is essential to identify needs, assess and prepare safeguarding plans for both mother and child.

Post-natal depression (PND) is very common among new parents and may affect as many as one in six new mothers, typically in the first three months after delivery, sometimes lasting for six months or up to a year if left untreated. Maternal post-natal depression can be significantly harmful to young infants particularly between the ages of six to eighteen months of age with increased incidence of insecure attachment. The depression itself does not cause the damage it is the effect of the mother child interaction and non-availability to the child that does the damage leading to emotional and cognitive difficulties, social withdrawal, negativity and distress (Cox et al 1987, Murray et al 1996).

Women in the postpartum period have a greater risk of becoming psychotic. Puerperal psychosis affects two percent of the general population but effect thirty to

fifty percent of women with a previous significant history of mental illness. Relapse signature can predict onset and nature of illness.

Dual Diagnosis

Substance misusing parents may have mental health problems. It is important, therefore, to maintain effective links between the agencies involved. It is important to refer to the Joint Service Protocol to meet the needs of children whose parents or carers misuse substances.

Workers should consider the impact, especially with chronic severe mental illness with co-morbid disorders such as substance misuse or a personality disorder will have on parenting capability. Those with a dual diagnosis of mental health needs and learning disability may require extra support.

Appendix 5: Fire Service Interventions

Juvenile Fire-setters Intervention Scheme (JFIS)

JFIS is a referral-based programme and works with children of all abilities up to the age of 18 years who have demonstrated any type of fire-play or fire-setting behaviour; from curiosity fire-play in younger children to deliberate fire-setting and arson in older teenagers. Referrals may come from parents/guardians, Youth Offending Teams (YOT), Social Services Departments (SSD) and a range of other services. Parental/guardian consent is required before any work is undertaken with children referred to the scheme.

The aim of the scheme is to address fire-setting behaviour by delivering fire safety education. Working one-to-one with children, each intervention is tailored to meet the child's individual needs. Through creating and developing a safe space and therapeutic relationship with the child, the case workers identify the motive for the fire-setting and then use a variety of age-appropriate fire safety messages and teaching methods to address the behaviour. Shock tactics are not used when working with a child, even if the parent/guardian asks for this approach to be considered.

JFIS is a free and confidential service. However, JFIS must and will share information with other agencies where required by statute.

Adult fire-setters can be referred to the scheme but each referral will be considered on a case-by-case basis by the scheme team leader to assess the needs of the individual and determine what other agencies are in place

If you would like more information or wish to refer a young person, please contact the Juvenile Fire-setters Intervention Scheme: firesetters@london-fire.gov.uk or call 020 8555 1200(x30842)

Home Fire Safety Visit (HFSV)

HFSVs are a free service offered to members of the public to help reduce accidental fires in the home. HFSVs help to reduce the risk of a fire occurring in the home and the resulting deaths and injuries by educating people of the risks that they personally face. The LFB believes that every home should have working smoke alarms because they give early warning should a fire occur and therefore can help people to escape before they are injured or killed. We may fit free smoke alarms in properties during the HFSV assessment.

In addition we provide a personally tailored escape plan in the event of a fire and give advice on the causes and other risks within the home.

HFSVs are carried out by LFB staff and in some cases, partners trained to deliver this service and can take place any day of the week, at any time that is convenient to the resident.

To book a free HFSV please follow the link or alternatively call 0800 028 44 28

Appendix 6: Guidance on Significant Harm and Children's Legal Context

The concept of significant harm

Some children are in need because they are suffering, or likely to suffer significant harm. The Children Act 1989 introduced the concept of significant harm as:

the threshold that justifies compulsory intervention in family life in the best interests of children. It lays a duty on local authorities to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer significant harm.

A court may make a care order (committing the child to the care of the LA) or supervision order (putting the child under the supervision of a social worker or a probation officer) in respect of a child if it is satisfied that:

- The child is suffering, or is likely to suffer, significant harm; and
- The harm, or likelihood of harm, is attributable to a lack of adequate parental care or control (s31).

There are no absolute criteria on which to rely when judging what constitutes significant harm.

Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, e.g. a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent or constituting significant harm. In each case, it is necessary to consider any maltreatment alongside the family's strengths and supports.

Under s31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002: 'Harm' means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another; 'development' means physical, intellectual, emotional, social or behavioural development. 'Health' means physical or mental health; and 'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under section 31(10) of the Act:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

To understand and identify significant harm, it is necessary to consider:

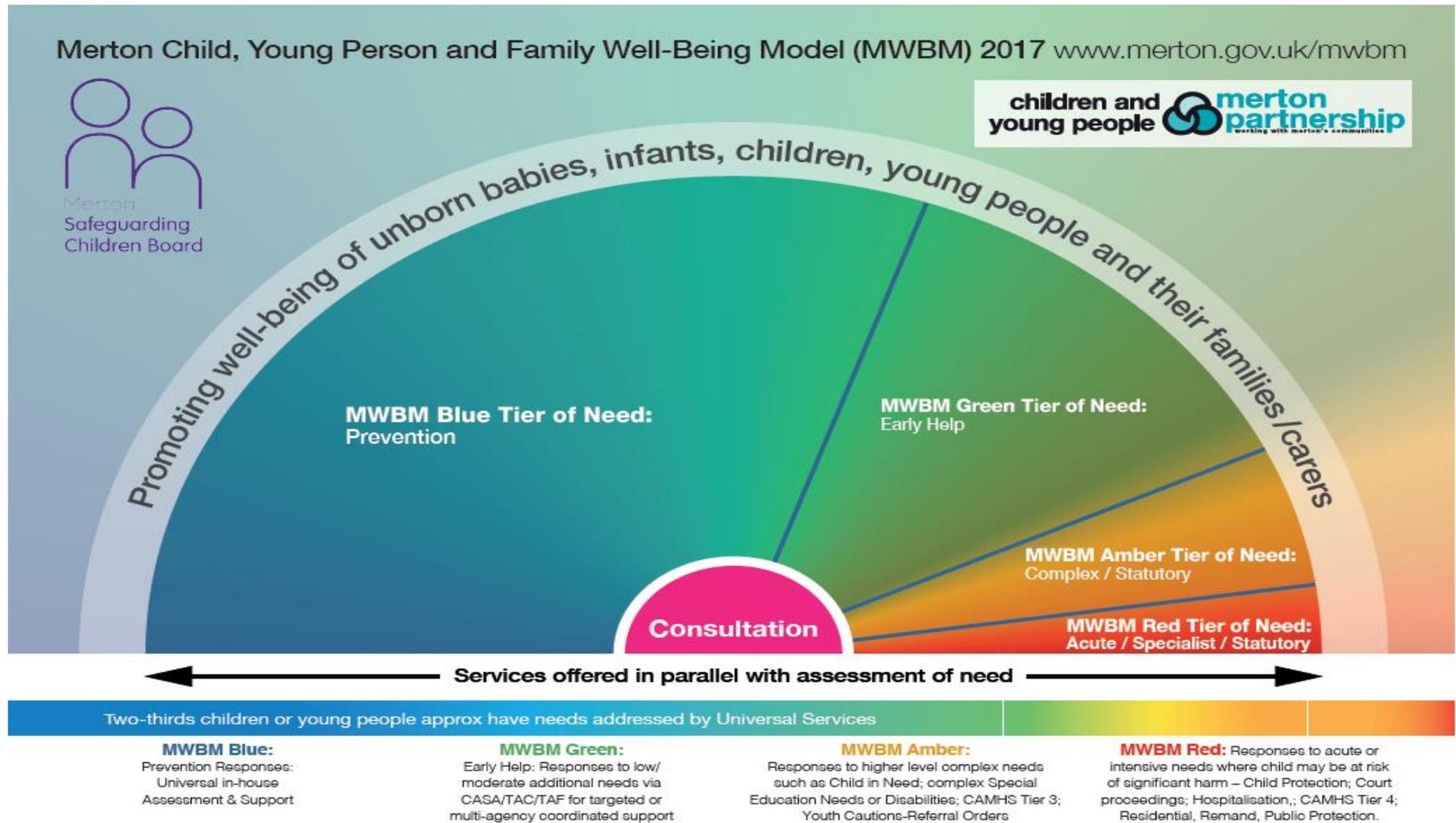
- The nature of harm, terms of maltreatment or failure to provide adequate care
- The impact on the child's health and development
- The child's development within context of their family and wider environment
- Any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family
- The capacity of parents to adequately meet the child's needs
- The wider and environmental family context.

The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and taken account of according to the child's age and understanding.

To do this depends on communicating effectively with children and young people, including those who find it difficult to do so because of their age, impairment, or their particular psychological or social situation. It is essential that any accounts of adverse experiences coming from children are as accurate and complete as possible. Accuracy is key, for without it effective decisions cannot be made and, equally, inaccurate accounts can lead to children remaining unsafe, or to the possibility of wrongful actions being taken that affect children and adults.

This Protocol was agreed and published November 2018

Appendix 7: The Merton Child, Young Person and Family Well-being Model



Appendix 8: References and Biography

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