Working Together
to Safeguard Children

Bedfordshire Local Safeguarding Children Board

Protocol for working with Parents/Carers who have mental health problems

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This document is available on the LSCB website www.bedfordshirelscb.org.uk

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Glossary of abbreviations

ASW	Approved social worker
BSP	Bedfordshire Safeguarding Procedures
CAF	Common Assessment Framework
CAMHS	Child and adolescent mental health services
CIN	Child In Need
CMHT	Community Mental Health Team
CP	Child protection
CPA	Care plan approach
CRHT	Crisis Resolution Home Treatment
CSC	Children Social Care
DCT	Disabled children's team
EDT	Emergency duty team
LSCB	Local Safeguarding Children Board
MAAG	Multi Agency Allocation Group
OT	Occupational therapist
PCT	Primary care trust

1 Introduction.

This protocol was commissioned by the Bedfordshire Local Safeguarding Children Board in order to develop a framework for Children and Mental Health services to work together in order to safeguard children and to promote their welfare.

A substantial proportion of adults known to the mental health services have children. In common with the population as a whole, most mentally ill parents are committed to their children and want what is best for them. To ensure that the needs of both parents and children are met, a high level of joint working is needed from both CMHT and CSC teams. This protocol provides guidance for Mental Health and Children professionals on working together to provide a seamless service that addresses the needs of families affected by mental health problems.

Being a parent with a mental illness is particularly challenging. Many are painfully aware that their disorder affects their children even if they do not fully understand the complexities.

All children, even very young children, are sensitive to the environment around them. Thus, their parent's state of mind has an impact on them. In this context all children are vulnerable when a parent has a mental illness. They can be identified as being young carers who are entitled to an assessment under the Children Act 1989 and Carers (Recognition and Services) Act 1995, Carers (Equal Opportunities) Act 2004.

Children in such families are vulnerable both on account of their parent's disorder and because of secondary factors that can accompany any chronic illness. Examples are low income, poor housing and neighbourhood, stressed family relationships and societal prejudice. Parents with mental illness need to be encouraged and enabled in their parenting without fear of prejudice.

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 children benefit from an age-appropriate explanation of their parent's illness. However, except in cases where there are safeguarding concerns, the parent's consent must be sought before talking to the children. Parents and relatives should be involved in discussions about why it is helpful for children to have information about their parent's illness.

2 Purpose of the protocol

Research studies demonstrate that a family-orientated, holistic approach is the most effective way of ensuring that the needs of the parents and children are met. In this way, the needs of the whole family can be assessed and addressed, with due regard for the safety of adults and children. Studies have also shown that good outcomes are achieved through effective interagency collaboration and flexible joint working across services and interfaces. This protocol sets out a framework of good practice for professionals and managers at all levels when working together with these vulnerable families and is consistent with the Safeguarding Procedures.

The main aims of the protocol are:

To provide a joint framework of assessment for adults with enduring mental health problems who are also parents, which addresses their needs and those of their children, in a way that:

- Considers the needs and safety of the children.
- Recognises the needs of the adults both as mental health service users and as parents.
- Acknowledges and understands the impact of mental illness on parenting and children.
- Supports family life and positive parenting.
- Promotes joint and multidisciplinary working across services and organisations.
- Provides a non-stigmatising service that encourages social inclusion for all users.

To improve interagency working practices by setting out details of each agency's referral and assessment procedures, including thresholds and timescales.

To provide a framework of quality assurance by outlining the service standards expected from each agency and the procedures for addressing any issues that may arise.

To improve interagency communication and information sharing through the use of a common policy.

3 Scope of the protocol

This protocol applies to:

- Community mental health professionals working in the community mental health teams.
- Social Workers working in the Bedfordshire Children's Social Care.
- Bedfordshire Mental Health and Social Care Trust staff based in hospitals.
- All other Professionals working with children and families within Bedfordshire.

4 Principles

- Children have a right to services that promote their physical and emotional well being and development so that they can achieve their potential
- The well-being of children and their families is best served by a multi-agency approach where different services work effectively together.
- The Childs/ren's welfare and safety is paramount
- Needs led approach
- All professionals involved have a responsibility for the safety and well-being of children
- Promoting child and parent participation
- Valuing and appreciating diversity
- Children are best placed within their families and support should be provided to enable this wherever possible and in the best interests of the child
- Clarity about accountability and responsibility to the child and mentally ill carer
- Parents with a mental health illness have a right to be supported in a non-judgement way that enables them to fulfil their parental responsibilities
- Risk is reduced when information is shared in a timely manner

The principles underpinning this protocol are encompassed in the Department of Health guidance, Working Together to Safeguard Children 2006:

2.52 NHS Trusts, Mental Health Trusts and NHS Foundation Trusts are responsible for providing health services in hospital and community settings. They must co-operate with the Local Authority in the establishment and operation of the LSCB and as statutory partners share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children. Representation on the board should be at an appropriate level of seniority. A wide range of their staff will come into contact with children and parents in the course of their normal duties. All these staff should be trained in how to safeguard and promote the welfare of children, be alert to potential indicators of abuse or neglect in children, and know how to act upon their concerns in line with LSCB procedures

2.92 Adult mental health services, including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services, have a responsibility in safeguarding children when they become aware of or identify a child at risk of harm. This may be as a result of service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area. Consultation, supervision and training resources should be available and accessible in each service.

2.93 In order to safeguard children of patients, mental health practitioners should routinely record details of patients' responsibilities in relation to children and consider the support needs of patients who are parents and their children in all aspects of their work using the Care Programme Approach. Mental health practitioners should refer to Royal College of Psychiatrists policy documents including Patients as Parents and Child Abuse and Neglect: the role of Mental Health Services.

2.94 Close collaboration and liaison between the adult mental health services and children's social services are essential in the interests of children. This may require the sharing of information to safeguard and promote the welfare of children or protect a child from significant harm. The expertise of substance misuse and learning disability services may also be required. The assessment of parents with significant learning difficulties, a disability, or sensory and communication difficulties, may require the expertise of a specialist psychiatrist or clinical psychologist from a learning disability or adult mental health service.

4.1 *Visiting of Psychiatric Patients by Children*

2.95 All inpatient mental health services must have policies and procedures relating to children visiting inpatients as set out in the Guidance on the Visiting of Psychiatric Patients by Children (HSC 1999/222: LAC (99)32), to NHS Trusts. Additional

guidance has been provided for high security hospitals. Mental health practitioners must consider the needs of children whose parent or relative is an inpatient, whether formal or informal, in a mental health unit and make appropriate arrangements for them to visit if this is in the child's best interests.

5 Confidentiality and 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 the guidance given in the Bedfordshire Safeguarding Procedures and Information Sharing Protocol, all available on the LSCB website www.bedfordshirelscb.org.uk.

5.1 *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.

5.1.1 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 issues and are able to make an informed decision. If not, the decision must be made by the person who holds parental responsibility for them.

Where an adult is deemed incapable of giving consent to disclosure, consent should be sought, where possible, from a person who has the 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.

5.1.2 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 who 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* both available on the LSCB website www.bedfordshirelscb.org.uk.

6 Role of the community mental health teams (CMHTS and CRHTs)

6.1 Adults

Community mental health teams (CMHTs) have lead responsibility for assessing and working with adults with severe and enduring mental health problems. On occasion, responsibility will lie with the GP or other health professionals who will liase with the CMHT as appropriate. CMHTs work in accordance with thresholds agreed between statutory agencies responsible for mental health services.

6.1.1 Referral and assessment procedures to CMHTs and CRHTs

If a parent referred to CMHT is not known but meets the criteria for assessment by the CMHT, this should be completed jointly by both services within their respective assessment frameworks. Procedures for joint

assessments can be found in section seven of this protocol.
If the parent is known to CMHT but his or her needs do not meet the threshold for allocation to a CMHT service, the CMHT should follow the information-sharing procedures outlined in section four of this protocol. The CMHT will advise on other possible sources of information or support, normally the person's GP. Where there continues to be concern, the CMHT will discuss the case with the CSC to help to identify and advise on alternative forms of support that can be offered to the parent.

Where an assessment indicates that a service user is in crisis and requires immediate psychiatric assessment and treatment, a referral should be made to the Crisis Resolution Home Treatment (CRHTs). Staff in the CRHTs will decide whether the service user should be admitted to a crisis bed, an inpatient service, the relevant CMHT or receive treatment from the CRHT.

The CMHT/CRHTs are multidisciplinary teams made up of mental health social workers (MHSW), community psychiatric nurses (CPN), psychologists and consultant psychiatrists. The CMHT/CRHTs undertakes assessments of mentally ill adults using the care programme approach (CPA). When a case is allocated in the team, the allocated worker is known as a care co-ordinator. This can be either a CPN, MHSW, psychologist or consultant psychiatrist, depending on the needs of the individual. The CPA care plan is reviewed regularly, depending on individual need.

6.2 Children

Mental health professionals have a duty to promote the well-being of children and safeguard them from harm.

Mental health professionals should routinely record the names and dates of birth of any children within the household of a service user, or of any children the user has parental responsibility or regular contact with and clarify whether the child/ren are a carer for their parent or other siblings due to their parents health issues. If possible, they should also record the names of the children's schools, their GP and any other health or social care professionals involved with the children or their family.

6.3 Criteria for child referrals

Where any of the following are present in an adult carer a referral should be made to Social Care for an assessment (see appendix C) or a CAF (see appendix B) can also be considered here to be carried out in order to determine how the child's needs can be met and the likelihood of significant harm.

- Delusional thinking involving the child
- Self-harming behaviour and suicide attempts
- Altered states of consciousness e.g. splitting/dissociation, misuse of drugs, alcohol, medication
- Obsessive compulsive behaviours involving the child
- Non-compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on the child
- Disorder designated 'untreatable', either totally or within timescales compatible with the child's best interests
- Domestic violence and/or relationship difficulties
- Unsupported and/or isolated parents
- A child is acting as a young carer for a parent or sibling

The threshold for significant harm is likely to have been reached when:

- There is an impact on the child's growth, development behaviour and/or mental/physical health
- The parent/carer's needs or illnesses are taking precedence over the child's needs
- There is insufficient alternative care for the child within the extended family

Factors associated with positive outcomes for children where a parent has a mental illness are:
- Mild parental problems lasting only a short time
- Minimal family disharmony and stability in family relationships
- One parent or family member able to respond to the child's needs

Children most at risk of significant harm are those:
- Who feature within parental delusions
- Who become targets for parental aggression or rejection
- Who are neglected as a result of parental mental illness
- Where mental illness is combined with domestic violence.

A study of 100 Serious Case Review's of child deaths where abuse and neglect had been a factor in the death showed clear evidence of parental mental illness in a third of the cases[1].

It is not necessary to have a formal diagnosis in order to complete the assessment. Section 47 enquiries/core assessments should focus on identifying parental behaviours and considering their potential impact on the child.

The following table may assist in the assessment process[2]:

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

If it is believed that the child would benefit from family support services, professionals may refer the child but only with the consent of the person with parental responsibility.

Eventually, all agencies will use a common assessment framework (CAF) and training on its use will be provided. In the meantime, professionals can refer to appendix 2 of this protocol for guidance on what level of needs a child has and what appropriate action should be taken. Medium is borderline 'child in need'; some children will be eligible for a service, others may be referred to other agencies. Children who exhibit needs at

[1] Falcov, A. (1996) A Study of Working Together 'Part 8' reports *Fatal Child Abuse and Parental Psychiatric Disorder* DoH ACPC Series 1 London
[2] Duncan, S., & Reder, P. (2000) "Children's experiences of disorder in their parents" *in* Reder, R., McClure, M., Jolley, A. (eds) (2000) *Family Matters* Routledge: London

high must be referred to CSC as statutory intervention may be required.

Adult services may consider a referral to the Multi Agency Allocation Panel (MAAG) if appropriate for level 2 cases that do not meet social care criteria. A referral can be made by using the CAF referral form on www.bedfordshirelscb.org.uk and send to either maagnorth@bedscc.gov.uk, maagmid@bedscc.gov.uk or maagsouth@bedscc.gov.uk

6.4 Referring to Children and Families

If a mental health professional has concerns about the safety of a child they should speak to their manager or other lead professional (i.e Named Nurse) and make an immediate referral to the relevant CSC Intake and Assessment team. The referral should be followed up in writing within 24 hours using the Common Assessment and Multi Agency Referral Form available on the LSCB website www.bedfordshirelscb.org.uk .The parent or carer should be informed of the referral unless there are sound contraindications, for example if the child protection investigation or the future safety of the child could be compromised.

If there is no immediate risk but there are concerns that the child's needs are not being met, the mental health professional should check whether the child or family is known to CSC. If they are not known, the child should be referred, with the permission of the person who has parental responsibility, to the CSC Intake and Assessment team, followed by a referral in writing within 48 hours. Mental health professional should also check with the CAF administrator to see if a CAF has been completed and if so who the lead professional is.

If the decision is made by CSC to undertake an Initial and/or Core Assessment then there needs to be some agreement/decision as to whether this is a joint assessment as the issues around the parent/carers ability to meet the needs of the child/ren will need to be assessed taking into account their mental health problems. CSC workers are not experts in this field and therefore the input of CMHT workers is essential.

If the situation is considered by CSC to be below the threshold for a service (see appendix 2 for details of thresholds), they will advise on other services available, a referral to the Multi Agency Allocation Panel maybe appropriate. If there is no immediate risk to the child, and the person with parental responsibility is in agreement, the mental health professional can refer the children or family directly to other services for children such as the Young Carers Project, CAMHS, play services or

can use MAAG for access to these services. See appendix b for contact details.

7 Role of Children's Social Care

7.1 Children

The lead agency for children is the CSC of the local Authority.

7.2.1 Referral and assessment procedures

When a referral is accepted by CSC an initial assessment will be undertaken. This must be completed within **7 working days** of the referral being received. The assessment should be planned jointly with other involved professionals, unless the concerns are so urgent that immediate action (S47 enquiries) needs to be taken by the social worker to ensure the child's safety. In this case the mental health professional should be fully informed and be part of the child protection strategy discussion or meeting.

The initial assessment will proceed to a core assessment if:

- The needs of the parents or carers are complex.
- The children's needs are complex although the adult's condition is stable.
- There have been two or more initial assessments undertaken during the last
- 12 months.

A core assessment is an in-depth assessment and must be completed within **35 working days** of the referral being received. At the start of a core assessment, a planning meeting should be convened to which all relevant professionals and agencies and the family are invited. This meeting is an opportunity to plan the assessment with the family, and to decide which service will take the lead.

Following the meeting, a written agreement should be drawn up and circulated to everyone who attended the meeting, including the family and other agencies as appropriate.

If at any time during the core assessment the children are considered to be at risk of significant harm then child protection procedures will be invoked in line with the BSP. There may be an additional in depth parenting assessment by Children's Services family support service, which would also need input from mental health services

7.2 Adults

Children social workers should routinely record whether a parent has a mental health problem and who is treating this. If the adult does not meet the threshold of the CMHT, then their GP can be contacted for advice.

7.2.1 Referral to CMHT

If a Children social worker has concerns about a parent's mental health, they should check whether the adult is known to the CMHT. See appendix b for contact details.
All referrals should be made by phone to the relevant CMHT duty team depending on the parent's address.
If an adult with mental health issues is at imminent risk to themselves or there is a risk to the community, they should be referred to their care co-ordinator.
If they do not have a care co-ordinator or the care co-ordinator cannot be contacted, the person should be referred to the approved social work service (ASW) who will assess the situation and act accordingly. The ASW service can be reached via the mental health duty system.

8 Procedures for joint working

In situations where both CSC and CMHT continue to have an ongoing involvement with a family or are carrying out a joint assessment of the parent, the parent's mental health professional and the child's social worker must be invited to all meetings and reviews that are held by each of the services.

Throughout the assessment process, there must be:

- Clear communication between the services.
- Sharing of individual assessments.
- Joint planning for ongoing work and services that is recorded in the files of both services.
- A clear indication, recorded on the case files, as to how, when and by whom the plan will be reviewed.
- Sharing of information with the parents or carers, unless this would put the child in more danger or compromise S47 enquiries.

No major decisions (such as the removal of children, closure of case or move to discharge from hospital) should be made without the consultation of other services, unless urgency requires immediate action. In these circumstances other parties should be informed as soon as possible.

The mental health worker **must** be informed if a child is returning home following a period of being in care or of accommodation and the Children social worker must be informed of any changes in treatment, such as a trial on reduced or no medication.

If the parent does not agree to the Children social worker being invited to their CPA meeting, the care co-ordinator will discuss with the patient their objections and the importance of professionals working together for the benefit of themselves and their children. It may be possible to negotiate for the Children social worker or another children's worker to attend part of the meeting.

The health visitor should be invited to all CPA meetings where the service user has a child under five years', or a School Nurse for a child over 5 whether or not the child is known to Children Social Care.

Whether or not child care professionals attend the CPA where there are concerns about the well-being of the children, the need to share information takes precedence over the patient's right to confidentiality. See pages 8-9 on confidentiality and information sharing.

Written documentation or minutes must be sent to all professionals involved and put on the respective case files.

Regular communication by telephone, fax, email or letter should be maintained, particularly if there are any concerns or changes in the situation.

If appropriate and practical it is good practice to arrange joint visits from time to time. Otherwise, agencies should co-ordinate visits from CMHTS and CSC to ensure families are seen regularly.
In some circumstances it will be appropriate for a service to provide input, and for other agencies to provide consultation.

If any agency plans to close a case, the other agencies must be informed in writing as soon as the decision has been made, outlining the reasons and the alternative support systems in place.

9 Inpatient services

9.1 Admission

When an adult is admitted to an inpatient psychiatric ward, the admitting nurse should enquire if the person has parental responsibilities or regular contact with children and make routine enquiries. They should note any childcare issues on the nursing assessment, including:

- Details of who is looking after the children.
- Any concerns about the care of the children while the patient is on the ward.

- Any issues about visiting, taking into account ward policy.
- Issues about parental leave.
- Any involvement of other agencies, particularly with CSC.
- Who the other significant others are i.e. with Parental responsibility, this is particularly important when the patient has not got ‘parental capacity’.

Pregnant women admitted to hospital should be referred to CSC according to the address of the patient. If, due to the nature of the patient’s illness or for any other reason, it is not possible to gather information about the children, this should be sought from other sources available. In the first instance, ward staff should contact the relevant CSC Intake and assessment team to see if the family are known, if it is believed that there are children involved. Any gaps in information about a patient’s child or children should be noted in the case records and must be followed up with the patient, their relatives or other professionals involved, for example the GP or health visitor, within five days.

9.2 Patient known to Children and Families

Where a patient is known to CSC, then they should be:
- Informed about admission as soon as possible.
- Informed if the patient is going on leave.
- Informed if the patient is absent without leave.
- Involved in planning for the patient’s discharge.
- Informed if the patient’s discharge is imminent, whether or not joint planning has been possible.

It is not sufficient to leave messages about a patient on voicemail or answer phone; all voicemails should leave a number that can be dialled and which will be answered by a social worker in person.

Information must be left with the patient’s Children social worker, the duty worker or the relevant administrative officer and a record made of the person spoken to.
Out of normal office hours, information should be passed to the emergency duty social worker 0870 2385465. It should then be faxed to the relevant duty team the next working day.

If CSC are involved with a patient, or accept a referral, they should be invited to all care planning meetings under the CPA.

If the patient does not agree to the Children social worker being invited to their CPA meeting, the ward manager or senior nurse will discuss the patient’s objections with them and explain the importance of professionals working together for the benefit of themselves and their

children. It may be possible to arrange for the Children social worker or another children's worker to attend part of the meeting.

Where there are issues about children's welfare, discharge plans must involve and be agreed by all professionals working with the family. Copies of plans must be filed in both adult CMHT and CSC files.

9.3 Patient not known to Children and Families

If the patient and their family are not known to CSC, the patient's care co-ordinator in the CMHT should be informed as soon as possible. They will refer the family to CSC or other services as deemed appropriate.

If there is no care co-ordinator or the care co-ordinator is not available and the situation is urgent, the admitting or primary nurse must consult the ward manager or senior nurse. They will decide if a referral to CSC is required following safeguarding procedures, if the child is considered to be at risk of significant harm.

If there are no significant harm concerns then a referral to CSC will require the agreement of the patient or other person with parental responsibility.

10 Finance

The appropriate financial procedures for each service must be followed.

Where additional financial resources are required, the circumstances of the whole family must be addressed and consideration given to using Section 17 monies under the Children Act 1989 or the Fair Access to Care Services procedure or both. Consideration should be given to the consequences of not providing the service. . The needs of the parent and children should be clearly identified in planning/discharge meetings so that appropriate packages of support can be costed and agreed, if appropriate.

In some circumstances, one or other service will have the financial responsibility, or there may be an agreement to apportion costs.

11 Resolution of disputes and differences

The aim of this protocol is to encourage decisions to be taken jointly and to ensure that the needs of both the children and the mental health service user are addressed within the framework of legislation and codes of practice.

In the event of a dispute or disagreement arising between professionals, in the first instance the matter should be discussed between the respective line managers. If the differences cannot be resolved at this level within a reasonable timescale, then the matter should be referred to the Head of Intake/Assessment and Family Support for CSC and the equivalent senior manager in the CMHT.

Any disputes involving cases where there is a possible risk to a child should be referred to the Head of Quality Assurance at the relevant local authority. Any disagreements or differences should be recorded on the case file, including the views of the other party.

12 Training

All Professionals dealing with children and families are expected to undertake Safeguarding training.

Frontline Children and Adult social workers should attend the Local Authority in-house Crossing Bridges training. Frontline children social workers should also attend Safeguarding in-house training.

All Professionals will have access to the interagency training approved by the LSCB.

Both mental health professionals and Children social workers should endeavour to attend all relevant joint training events. These events will encourage an understanding of each agency and working practices, which in turn will help to promote positive interagency working.

Appendix A

Descriptions and categories of mental disorders

It should be noted that categories and descriptions of mental disorders vary across time and within different cultures. The important point is how the symptoms impinge on the life of the individual and, in the context of parents with mental health difficulties, their parenting capacity and the impact the symptoms have on their children.

Definitions

Schizophrenia
Schizophrenia is likely to affect 1 person in 100. 1 in 3 of the people affected by schizophrenia will, with the right treatment, make a full recovery. For others the illness can be a debilitating and enduring disorder. For the vast majority of service users their condition can be effectively controlled with medication. The symptoms may include:

- Hallucinations: Seeing, hearing, feeling or smelling something others around the person cannot.
- Delusions: False beliefs or believing something is real when it is not, for example people think they are famous, someone is controlling their thoughts, and they have special powers.
- Thought disorder: muddled thoughts or speech.
- Loss of feelings or emotions.
- Loss of energy and interest. The individual may become withdrawn or behave out of character.

Bipolar disorder

Bipolar disorder is characterised by mood swings between elation and depression. It is an enduring disorder but can be controlled by medication. During manic episodes a person with bipolar disorder will tend to be:

- Hyperactive: always on the move. They may be able to manage with very little sleep.
- Disinhibited and take risks, for example start overspending and run up debts or set in motion unrealistic schemes with unfortunate consequences.
- Hold false beliefs, often of a grandiose nature.

During a depressive phase the person suffers from:

- A sense of hopelessness and despair. This can lead to thoughts of suicide, which must be taken seriously.
- Loss of energy.
- A desire to withdraw from people and be on their own which can exacerbate the feelings of loneliness and despair.

- A lack of motivation which may impede everyday activities such as eating, sleeping and generally looking after themselves and their families.
- Feelings of low self-esteem and vulnerability resulting in the person being over-sensitive and experiencing him or her to be bad at everything they do.

Schizo-affective disorder

Symptoms of schizophrenia with mood swings.

Clinical depression

The symptoms of clinical depression are similar to those described in the low phase of bipolar disorder. Clinical depression differs from feeling ‘low’ which most people experience from time to time in that the symptoms of hopelessness, lack of motivation, worthlessness, low self-esteem and exhaustion are long standing and usually unrelenting. They give rise to poor concentration, disrupted sleep patterns, and poor appetite. These factors impinge on the person’s daily living and ability to carry on normal family, social and work life. This can set off a vicious circle – the worse the person feels the more depressed they get and so on.
Treatment is usually medication possibility accompanied by one of the ‘talking therapies’: counselling, psychotherapy or cognitive behavioural therapy (CBT).

Anxiety

Pathological anxiety is constant and unrealistic worry about daily life. It can affect the person’s ability to concentrate, leading to restlessness and disturbed sleep patterns. It may also give rise to physical symptoms such as rapid heartbeat, digestive upsets, tensions in muscles giving rise to aches and pains.

Phobias

A phobia is an unreasonable fear of a situation or object. It can cause disruption to a person’s life if it imposes restrictions on the way they live.
For example agoraphobia, a fear of going out or open spaces can result in a person becoming isolated in their own home, unable to work, shop or socialise. Alternatively claustrophobia, a fear of enclosed spaces can affect activities such as shopping, or going to cinema or anywhere that is crowded. Other phobias include a fear of animals, heights or flying.

Obsessive–compulsive disorder

This occurs when a person has to repeat actions over and over again for example checking that the doors are locked or washing their hands. In severe cases the repeated actions can take hours and allow little time for daily living. The obsessions may also affect thoughts and ideas which the person cannot get out of their head and often become circular so that a resolution or decision cannot be reached.

Eating disorders

Eating disorders are characterised by extreme preoccupation with food or calories and bodyweight and shape. The person with an eating disorder often has a distorted body image, believing themselves to be overweight when they are extremely underweight. They may also have rituals around food and its preparation and have difficulty eating in the company of others.
There are two main types of eating disorder: anorexia nervosa and bulimia nervosa.

Anorexia nervosa

In anorexia nervosa the person restricts their eating and loses weight. The restriction is often accompanied by a sense of triumph over being in control and able to manage without food. In reality the control quickly gives way to an overriding fear of food. Restriction of food intake gives rise to physical symptoms, for example cold extremities. In women periods cease and, in extreme cases, the starvation can be life-threatening. People with anorexia may also exercise compulsively as a means of controlling shape and weight.

Bulimia nervosa

In bulimia nervosa, while still preoccupied by food and bodyweight and shape, the person has episodes of overeating when they will feel out of control. These are referred to as binges; in extreme cases the sufferer may eat anything and everything they can get their hands on. A binge may be followed by vomiting, taking laxatives or occasionally diuretics as a means of getting rid of the calories. As in anorexia, they may also exercise compulsively. Binges can alternate with periods of restricting food intake.
When the person binges without vomiting, using laxatives or exercising excessively, the condition is called Eating Disorder not Otherwise Specified (EDNOS).
Treatment is usually by specialist units, which address both the physical and psychological aspects of the illness.

Appendix B

Children Social Care

Bedford Intake and Assessment Team
Kingsway
Bedfordshire County Council MK42 9BG
Tel 01234 223599

Dunstable Intake and Assessment Team
County Offices
Vernon Place
Dunstable
LU5 4EZ
Tel 01582 818499

Common Assessment Framework (CAF) and Multi Agency Allocation Groups (MAAG)

Access to Services

As well as having the appropriate range of services, we strive to make sure that the following principles underpin the allocation of services:

• early assessment of need leads to earlier intervention and the promotion of children's well-being
• services provide timely, needs lead response
• work with children, young people and their families takes an holistic approach, building on strengths and developing resilience factors
• services are efficiently co-ordinated, and where appropriate a Lead Professional identified.
• all work has clearly identified outcomes.

In Bedfordshire, the three key processes that are in place to promote early intervention are the Common Assessment Framework (CAF); the Lead Professional, and the Multi-Agency Allocation Groups (MAAG). There are also panels in place that meet the more complex levels of need – Bedfordshire Allocation Panel (BAP) and Joint Agency Panel (JAP). These panels allocate intensive family support and specialist residential care provision.

Early Intervention & Prevention in Bedfordshire

Key principles of early intervention are:
• a broad range of services,
• early assessment of need leads to earlier intervention,
• services provide a timely, holistic response,
• services work together towards identified outcomes.

What is the Multi Agency Allocation Group (MAAG)?

Bedfordshire's Multi Agency Allocation Group (MAAG) has been developed by the Children & Young People's Strategic Partnership (CYPSP) to deliver timely, responsive, needs led services to children, young people and families.

Three MAAG panels have been set up in south, mid and north Bedfordshire. They meet fortnightly to identify the services that could best support children and families referred to them.

MAAG is a multi agency group that uses the skills, knowledge and expertise of a variety of services for the benefit of children and their families. This approach also ensures that families do not have to be passed from one service to the next and repeat their stories. The MAAG panel also acts as the Youth Inclusion Support Panel, is school facing and aims to provide early interventions that are seamless and timely.

What are the responsibilities of MAAG members?

Every member is there to:
• represent their service,
• bring their experience and skills to the group,
• liase and feed back information to their own service or organisation about referrals to MAAG,
• promote MAAG within their service or organisation,
• to be able to agree to allocate work from MAAG on behalf of their service,
• bring local knowledge about services and the communities they work in.

How are families referred?

Any agency can refer to the MAAG using the multi agency referral form or CAF. A decision sheet will be sent to the referrer after MAAG meet. The referrer must then share that information with the family and liase with services that have been allocated.

The types of difficulties that services can help with include:
• behaviour
• communication
• emotional
• relationships
• child development
• play and stimulation
• school attendance and learning
• substance & alcohol misuse
• parenting
• making sense of life experiences
• mental health
• social skills

Disagreements

If a family or referrer is unhappy with MAAG's decision then the referrer should discuss this with the Chair of the MAAG. If the Chair agrees the case may be discussed again. If there is a disagreement regarding the way the service is provided

this must be communicated through the agency providing the service, their representative on MAAG, the person carrying out the work or their manager. If there is a Lead Professional they may also be contacted to resolve any difficulties.

How are services reviewed?

Any services allocated by the MAAG will be reviewed by the agency providing them. The Lead Professional will also review how things are going. If more help is required the case may be discussed by the MAAG again. An audit / evaluation process for CAF and MAAG has been developed and will be implemented in 2007.

Sharing information and confidentiality

Having a multi agency group means that members must share information with each other to identify the most appropriate services for families. The MAAG referral form asks for families consent to have their information shared at MAAG. All of the information requested is kept at the minimum level necessary. Both MAAG and CAF use the information sharing guidelines produced by the Local Safeguarding Childrens Board.

- **In order to help agencies work together, they need to share information about people they are working with.**
- **It is vital that the referrer obtains the families consent for this, before referring to MAAG**

Common Assessment Framework

Bedfordshire's MAAG works alongside the Common Assessment Framework (CAF) and Lead Professional (LP) system. The CAF is an assessment tool introduced by the Dfes across the country, as part of the Every Child Matters agenda.
The CAF enables a group of professionals and the family to:

- pool their knowledge of the child and family,
- identify areas of needs and strengths in the family,
- agree a shared view of desired outcomes that everyone is going to work to for the child,
- appoint a Lead Professional who will co-ordinate the work.

Lead professional

A Lead Professional may be appointed when more than one service is working with a family. This will be from the network of professionals already working with the family and will not be a specific post or an extra professional added to the network. This will ensure that someone has responsibility for:

- liasing with a network of colleagues,
- co-ordinating the services that families receive and contributing to reviews,
- ensuring that families have a good understanding of the services they are receiving or which might be available to help them,
- advocating on behalf of families.

Contact details

All referrals to the MAAG are dealt with electronically and by area. They can be sent to:

Maagnorth@bedscc.gov.uk
Maagsouth@bedscc.gov.uk
Maagmid@bedscc.gov.uk

The MAAG/CAF administrator is available on **01234 276750**
Completed CAF's should be sent to: **CAFadmin@bedscc.gov.uk**
Full details of the CAF training and implementation, including guidance and the CAF form, are available on **www.bedfordshirelscb.org.uk**
MAAG and CAF are managed through the Children's Services Commissioning Team. The Head of Commissioning (Family Support and Integration) is Warwick Tomsett, who can be contacted on **01234 276712**, or email **warwick.tomsett@bedscc.gov.uk**

Community Mental Health Teams

It is estimated that one in four people will at some stage in their life be affected by a mental health problem. These can range from short-term problems to longer term ones. However, our highly trained doctors, psychiatrists, psychologists, psychotherapists, community mental health nurses and support workers can help our clients in leading a normal and fulfilling life.

Our services include:

Day Care Services
Secure Services
Acute In-patient Services
Assertive Outreach
Employment Services (ACE)
Acute Community Mental Health Teams
Crisis Resolution & Home Treatment
Eating Disorders Service
Rehabilitation & Recovery Services
Occupational Therapy Services
Psychology Services
Drug and Alcohol Services

For further information about the above services see www.blpt.nhs.uk.

Bedfordshire and Luton NHS
Mental Health and Social Care Partnership NHS Trust

Information About Trust Sites

<table>
<tr>
<td>
<u>Crisis Resolution Home Treatment Teams</u>
Description: Crisis service for service users in immediate need of care and support
Address: Bedfordshire CRHT Team,
Bedford Heights,
Manton Lane,
MK41 7PH.
01234 315 692

Luton CRHT Team
Limetrees,
Calnwood Court
Luton,
LU4 0DZ
Telephone: 01582 556 971/ 556 975
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<td>
<u>Beacon House</u>
Description: Outpatients unit and base for Community Mental Health Team(CMHT). Befrienders and other voluntary and self help groups provide social activities and support at the house.
Address: 5 Regent Street
Dunstable
LU6 1LR
Telephone: 01582 709200
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<tr>
<td>
<u>Calnwood Court</u>
Ground floor
Description: Base for Community Mental Health Teams (CMHTs),
Out-patient clinics, Patient Benefit Office and team administrators.
Address: Calnwood Court
Calnwood Road
Luton
LU4 0LU
Telephone: 01582 709150
</td>
<td>
<u>Crombie House</u>
Description: Outpatients unit and base for Community Mental Health Team (CMHT). The Befrienders and other voluntary and self help groups provide social activities and support at the house.
Address: 36 Hockliffe Street
Leighton Buzzard
LU7 1HJ
Telephone: 01525 751133
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<tr>
<td>
<u>Fountains Court</u>
Description: A 26-bedded unit, purpose built for older people with Alzheimer’s or other related dementia’s who require long-term specialist care (i.e. older people with behaviour disturbance).
Visiting times: There are no restrictions on visiting times.
Address: North Wing
Kimbolton Road
Bedford
Bedfordshire
MK40 2NY
</td>
<td>
<u>Limetrees</u>
Description: A 22-bedded assessment unit catering for the needs of clients over the age of 65 who have dementia or mental health problems (organic or functional mental health problems). Also the base for Luton’s Crisis Resolution and Home Treatment Service.
Visiting times: Monday - Friday (4:00pm to 8:30pm)
Saturday - Sunday (2:00pm to 8:30pm)
Address: Calnwood Road
Luton
</td>
</tr>
</table>

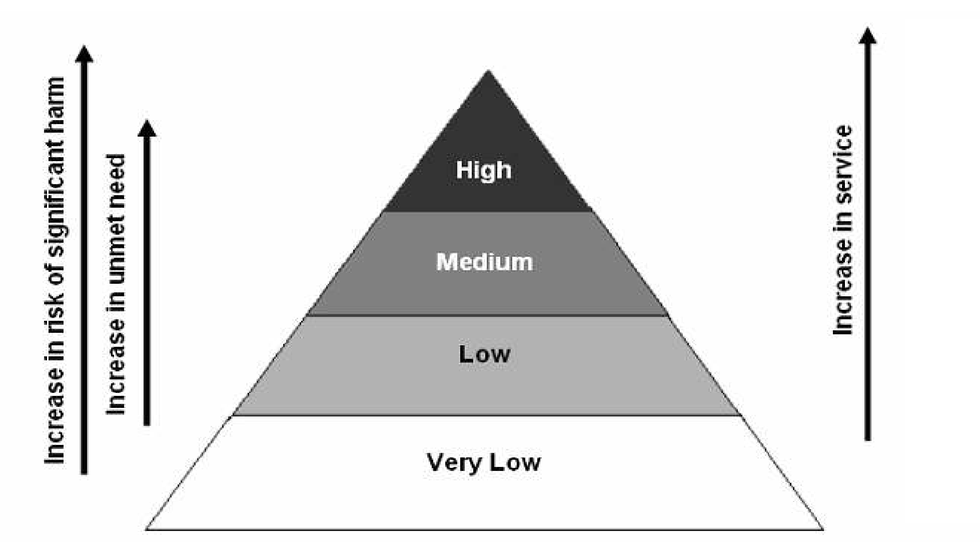
Telephone: 01234 310798	Bedfordshire LU4 0FD Telephone: 01582 707555
Milton Ward - Weller Wing Description: 15-bedded inpatient ward that provides assessments and treatment for people over the age of 65 who have dementia and other organic illnesses. Visiting times: Monday – Friday (4:00pm to 8:30pm) Saturday – Sunday (2:00pm to 8:30pm) Address: Milton Ward Weller Wing Kempston Road Bedford, Bedfordshire MK42 9DJ Telephone: 01234 299946	**Oakley Court** Description: 25 bed acute in-patient unit and base for the Continuing Care Team and Assertive Outreach Team responsible for Luton. Address: Angel Close Off Addington Way Luton LU4 9WT Telephone: 01582 709180
Orchard Unit **Orchard 1** Description: 16 bed low secure unit Address: Calnwood Road Luton LUF 0FB Telephone: 01582 657531 **Orchard 2** Description: 16 bed low secure unit and base for the Court Diversion and Orchard Assertive Outreach Team. Address: Calnwood Road Luton LUF 0FB Telephone: 01582 657544	**Sheridan Day Hospital** Description: Provides care, assessment and treatment for a limited period of time (usually 6 to 12 weeks), to people who are generally over the age of 65 and are experiencing problems with their mental health. Provides 15 places per day. Visiting times: Monday – Friday (8:30am to 4:30pm). The Day Hospital is closed on Bank Holidays. Address: Sheridan Day Hospital Weller Wing Kempston Road Bedford, Bedfordshire MK42 9DJ Telephone: 01234 299970
The Poplars Description: A 22-bedded assessment unit purpose built for people over the age of 65, who have both functional and organic problems, (dementia and mental health problems) Visiting times: Monday – Friday (4:00pm to 8:30pm) Saturday – Sunday (2:00pm to 8:30pm) Address: Mayer Way Houghton Regis Dunstable Bedfordshire LU5 5BF Telephone: 01582 657589	**Townsend Court** Description: 25 bed acute in-patient unit with an additional 2 beds for eating disorders and 3 beds for Substance Misuse, (drug and alcohol detoxification programme). The unit also provides Day Care for 8 patients. Address: Mayer Way Houghton Regis LU5 5BF Telephone: 01582 707600

Weller Wing	
Description: Treats acute adult mental health patients on Keats ward (24 beds) Also has two wards for older people - these being Chaucer Ward (15 beds) and Milton Ward (15 beds). Sheridan Day Hospital is also situated at the unit, as well an Occupational Therapy Department. Address: Southwing Hospital Ampthill Road Bedford MK42 9DJ Telephone: Keats Ward 01234 299955 Bronte Ward 01234 299966 Chaucer Ward 01234 299966 Milton Ward 01234 299946	

Appendix C: Bedfordshire's Thresholds for Intervention

In Bedfordshire we have adopted four levels of priority based on Hardiker et al levels of intervention described in *Policies and Practices in preventative childcare* 1991 Avebury/Gower. This is for CSC involvement so it does not mean that other services may be appropriate/available at the low/very low – accessible via MAAG.

Pyramid of Need



'Very Low':

- Children from families where there are difficulties that can be more appropriately addressed by universal services.
- Children whose health and development is not being adversely affected.

'Low'

- Children from families where carer(s) are experiencing difficulties which **may** affect the child's health or development.
- Children whose health and development **may** be affected.
- Children that fall within the definition of 'In Need'.
- Children and families where there is a **risk of deterioration** and the child's health or development **may** be affected in the near future.

'Medium':

- Children whose health and development **is or may be** impaired.

'High':

- Children **experiencing significant harm** or where there is a **likelihood of significant harm.** Children at risk of removal from home

Framework for assessing children's needs

(Based on Hardiker et al model of intervention)

PRIORITY LEVEL	EXAMPLES OF NEED	EXAMPLES OF SERVICES	LEVEL OF ASSESSMENT	TIMESCALE
VERY LOW	Parent's separating with impact on child	RELATE	Signposting *or* Referral to other agencies	
	Low income	CAB, Welfare benefits, Benefits agency, Job centres		
	Lack of access to play and leisure Lack of family and community support	Children's Information Service Community Education Leisure services + BCC Youth Service Parent and toddler groups Pre-school learning Sure Start		
	Child not achieving school potential School non-attending	Education welfare officer pupil support		
	General parenting advice	Parenting programmes Sure Start		
	Cultural/linguistic/access	Interpreters Section 11 funding by relevant agencies Health visitors		
	Employment and life opportunities for older children	Parenting programmes in schools Connexions		
	Sub-standard housing	Housing authorities Community centres		

PRIORITY LEVEL	**EXAMPLES OF NEED**	**EXAMPLES OF SERVICES**	**LEVEL OF ASSESSMENT**	**TIMESCALES**
	Child falls within definition of “In Need”			
	Short term help with family crisis	Short term focussed social work intervention	Initial assessment	Decision to undertake made in 24 hours 7 working days to
	Family relationships impacting on child	Counselling Family work Relate Community based family centres Supported playgroup placements		
	Child has Education/Health problems where home situation is contributory e.g. : Parent is young Parent/carer has physical/learning disability Signs of substance misuse Persistent bullying Domestic violence	Community based ‘treatment’ centres Adult mental health services CAMH services Adult Learning disability services Education Welfare service Material/financial assistance Home visiting services e.g. Homestart, Health e.g. health visitors Children’s centres		

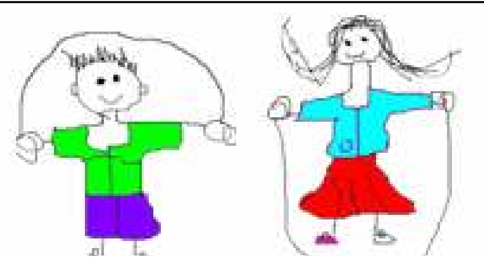
LOW PRIORITY	Child with disability and parents ability to cope is affected Child with disability, but ability to participate in leisure/social activities appropriate to their age/development affected Child with disability whose needs effect development of other children in the family to some degree	Family Link Home support services Residential respite CAMH services Primary and Secondary learning support services Educational psychology Health visitors Young Carers projects		complete
	Poor parenting impacting on child Children fostered by private arrangement	Parenting programmes Monitoring by social worker/fostering & adoption worker		
	Children who are carers	Adult social services Young carers project		
	Children who offend	Befriending services Pre-court services YOT YMCA Youth Matters SSD statutory requirements		
PRIORITY LEVEL	**EXAMPLES OF NEED**	**EXAMPLES OF SERVICES**	**LEVEL OF ASSESSMENT**	**TIMESCALES**
	Families with established difficulties, including substance misuse, violence	Social work with care managed children in need interagency plan Drug and alcohol services		
	Parenting difficulties	Family centre – individual programmes Outreach and detached Family support		
	Parental mental health problems	CAMH		

MEDIUM PRIORITY	impacting on parenting capacity	Young carers project GP/Adult mental health services	Initial assessment Core Assessment	7 days 35 working days
	Child/adolescent with suspected mental health problem	GP CAMH		
	Significant behaviour problems in child	Social work input Primary and secondary learning support services CAMH Health visitor		
	Child with complex disabilities/child with disabilities where parents cannot cope adequately with care needs	Home and outreach support services/consideration of residential respite Sponsored playgroup attendance		
	Child with disabilities unable to access leisure/social activities without substantial assistance	Social work input from CWD teams Statutory educational assessment Health learning disability services CAMH services Occupational Therapy Child development centres		
	Child with disability, whose needs prevent development of other children in family	Young carers project		
	Children who persistently offend	Supervised programmes through YOT Out of school provision Youth Courts Social services accommodation YOT		

PRIORITY LEVEL	EXAMPLES OF NEED	EXAMPLES OF SERVICES	LEVEL OF ASSESSMENT	TIMESCALES
HIGH PRIORITY	Child at risk of significant harm	Social work intensive help and long term support Multi-agency service package	Core assessment	35 working days
	Child with risk-taking behaviour including: prostitution serious substance misuse	CAMH Secure accommodation Drug and alcohol services		
	Child posing a high risk to self/others or vulnerable including: Absconding/running away from home 16-18 year olds leaving care situations of serious domestic violence	Leaving care services Supported accommodation		
	Unaccompanied asylum seekers	Social work support Family placement Counselling Residential care LAC consultant/nurse		
	Section 47 enquiries	Multi-agency services delivered from protection plan		
	Child needing to be looked after outside their own family immediately, following rigorous assessment	Family group conferences Family placement Foster care Residential care LAC consultant/nurse Education		
	Child on supervision or care order			

	Section 20			
	Child with severe emotional and psychological needs with resultant behaviour	CAMH Educational psychology		
	Mental ill health that poses a risk of harm to self or others	CAMH Secure accommodation		
	Child who persistently commits serious offences	Multi-agency Intensive support and supervision Secure accommodation YOT post custody supervision		
	Child with disability and family at imminent risk of breakdown Child with very high level of care needs – completely unable to access leisure/social activities Child with disabilities where needs of other children in family are not met	Family group conferences Respite or sustained accommodation Specialist/therapeutic placements CAMH Family placement Intensive social work input	Core assessment	35 working days

Working Together to Safeguard Children



Considering the welfare of children whose parents have mental health needs
Practice guidance for Adult Mental Health practitioners and all other professionals working with children

Principles

- Children whose parents have severe and/or on going mental health needs will usually be children in need in their own right. As part of the assessment of an adult with mental health problems practitioners need to consider how the adult's illness impacts on their children or those children with whom they have regular contact.
- By law the welfare of the child is paramount – this means that children's needs override those of the adult and that the welfare principle enshrined in the Children Act 1989 takes precedence over the Mental Health Act 1983 in all events.

Assessment Stage

Adult Practitioners will consider

- Who is in the family? (include age, gender, full names of dependent children)
- Does the child have special needs?
- Does the client have parental responsibility?
- What symptoms and behaviours does the adult exhibit and is the impact of these be on the children when acute/when chronic
- What other adults are involved in parenting?
- Is the client pregnant?
- Is the family known to children services (CAMHS/Social Care) if so what is the current involvement?
- Are there any previous/current concerns and do these relate specifically to mental health illness in the parent?
- Does the client have insight and willingness to accept support/services?
- Discuss with the client the availability of support for their parenting role from family or other services e.g. health visitor, CAMHS, Social Care, Parental Mental Health Service

If other children's services are involved

- Discuss with the client inviting key staff from other services to CPA meetings e.g. CAMHS, Health Visitors, Children Social Care
- Discuss with the client liaison/communication with those professionals outside of the CPA process

What to do

If you have no concerns for the child/ren

- Record
- Include parental issues in care plan at every review

If you have minor concerns for the child/ren which are not shared by the adult client, incl. pregnancy

- Discuss with your line manager and agree plan
- Informal discussion with Children Services and/or Parental mental health service to decide whether to make a referral and the level of urgency.
- If appropriate, discuss with client
- If concerns are shared by others and risks are posed to the child then refer without clients agreement
- In most instances, the client should be informed of the referral even if it is not with their consent as long as it does not place the child at further risk.

If you have major concerns about the welfare and safety of the child/ren

- Discuss with manager/supervisor
- Seek advice from the Trust-named nurse or Designated Doctor Safeguarding Children if you are not sure
- Refer to Children Social Care using the Multi Agency Referral form available on www.bedfordshirelscb.org.uk
- Agree with Children Social Care when and how to inform the client that a referral has been made

For Adults in Crisis

If the adult is admitted

- Consider how the impact on children can be minimised e.g. agree how contact can be maintained, what support and information the other carer and children need; who will explain the situation to the children and how.
- Discuss with Children Social Services as early as possible when it has been identified that admission may be required
- Ensure written information on the children and arrangements for their care is passed to Ward staff and all other children involved with the children and there is ongoing communication between all professionals and services involved
- As part of discharge planning, ensure support for the parenting role is included and appropriate professionals working with the children are invited to the discharge meeting or have the opportunity to contribute to the plan

If the parent is being looked after at home

- If the child remains at home, it must be remembered that the welfare of the child is paramount
- Ensure there is ongoing communication between all professionals and services involved
- As part of discharge planning, ensure support for the parenting role is included
- The safety and welfare of the child should be kept under constant review and consideration should be given to involving specialist child care services