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Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems

This thematic inspection by Ofsted and the Care Quality Commission explored how well adult mental health services and drug and alcohol services considered the impact on children when their parents or carers had mental ill health and/or drug and alcohol problems; and how effectively adult and children's services worked together to ensure that children affected by their parents' or carers' difficulties were supported and safe. The report draws on evidence from cases in nine local authorities and partner agencies and from the views of parents, carers, children, practitioners and managers. Please note that where references are made to 'children' in general terms in this report, this refers to children and young people up to the age of 18 years.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk

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Contents

Executive summary **4**
Key findings **5**
Recommendations **7**
Introduction **9**
Methodology **11**
Information gathered about children by adult services **12**
Overall 12
Mental health services 13
Drug and alcohol services 14
Identifying young carers 14
The contribution by adult services to early support for children 15
Referring concerns to children's social care services **16**
Overall 16
Mental health services 16
Drug and alcohol services 17
The response to concerns 18
Do children's services recognise when parents or carers need specialist assessment and support with mental health difficulties and/or drug and alcohol problems? 18
Assessments, support and intervention **19**
Overall 19
Mental health difficulties 19
Drug and alcohol problems 25
Multiple problems 29
The views of parents and carers 30
Views of children 30
Understanding, training and support **31**
Overview and evaluation **34**
Joint working strategies, protocols and planning 34
Monitoring, evaluation and quality assurance 37
Challenges to effective joint working **40**
Conclusion **41**
Further information **42**
Ofsted publications 42
Other publications 42
Annex: Providers visited **44**

Executive summary

No data are collected either nationally or locally about how many adults receiving specialised mental health services are parents or carers. Local areas visited had difficulty in identifying the numbers of children who were receiving support or intervention because of the impact on them of their parents' or carers' mental health difficulties. Better information was available about children whose parents or carers had drug and/or alcohol problems as local areas are required to gather information and report on this to the National Treatment Agency for Substance Abuse. As a result there was a stronger focus in adult services on identifying children who may be affected by drug and alcohol issues than on those who may be affected by serious parent or carer mental ill health.

Systems to identify children and consider their needs were comprehensive and used effectively in most drug and alcohol services. In mental health service records, however, it was difficult to identify easily whether or not adults were parents. While questions about children were included in recording systems and assessment documents, the clarity and detail of these varied and they were not consistently completed by practitioners.

Most adult mental health and drug and alcohol services were not proactive in helping families to access early support and they did not give enough consideration to identifying young people who might be taking on inappropriate caring responsibilities for parents or siblings.

When adult services identified concerns that reached the threshold for children's social care intervention they made appropriate referrals. However, in some cases adult mental health practitioners did not recognise and analyse the impact of the adult's mental ill health on the children and this led to risks not being recognised at an early enough stage. In the large majority of cases children's social care services responded appropriately to referrals; concerns were promptly followed up and assessments were undertaken. But in some cases adult practitioners had to make repeated referrals before children's social care decided to take action.

Drug and alcohol services had a good awareness of the needs of children and how drug misuse by parents and carers affected them. They worked closely with children's social workers and contributed well to assessments of need and risks for children, although the impact on the children's emotional needs was not always addressed. The quality of joint working between children's services and adult mental health services on children in need and child protection cases was more variable. The majority of assessments of children where parents or carers had mental health difficulties did not provide a comprehensive and reflective analysis of the impact of their mental ill health on the child.

When children received support and intervention as children in need, or were the subjects of child protection plans, this made a difference to their lives and outcomes for them improved in the majority of cases. However, in most of these cases there was a history of children's social care involvement, with difficulties in sustaining

improvements raising questions about the robustness of previous support and decisions.

Most Local Safeguarding Children Boards (LSCBs) did not have a clear grasp of the quality of joint working between adult and children's services as evaluation and auditing of this were not well established. Appropriate support and training were generally available, but opportunities for joint training were not always taken up, particularly by mental health practitioners. Records showed much stronger oversight of cases involving children by managers and designated staff in drug and alcohol services than in mental health services.

Key findings

- The extent to which adult and children's services worked effectively together to assess concerns and support and challenge parents and carers varied considerably. Overall, the quality of joint working was much stronger between children's social care and drug and alcohol services than between children's social care and adult mental health services.
- Thinking about the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services. This stronger focus on children by drug and alcohol services has been driven by the requirement for local areas to gather information on the number of adults with children and report on this to the National Treatment Agency for Substance Abuse. Within adult mental health services, while it is expected that the care programme approach considers safeguarding of children, there are no national requirements to gather information and report on the number of parents or carers who have serious mental health difficulties. Therefore, in the absence of any national drivers there is limited scrutiny of this issue within mental health services generally.
- Most adult mental health and drug and alcohol services were not proactive in helping families to access early support, though some drug and alcohol services had begun to promote this. Adult services practitioners were more likely to think about whether the family needed early support if a question on early support was included in the assessment tool. Young carers were not well identified.
- In almost all areas, clear and generally comprehensive systems were in place to identify if adults who had drug or alcohol problems were parents or carers and there was good consideration of the impact of this on the children. However, mental health services did not consistently consider the impact of the adult mental health difficulties on children. Questions about children were included in recording systems, but the clarity and detail of these varied and they were not always consistently completed.
- Drug and alcohol services consistently made timely and appropriate referrals when concerns reached the threshold for children's social care intervention. When adult mental health services identified concerns about children they also referred

these appropriately to children's services. However, in some cases a lack of reflection on, and analysis of, the impact of the adult's mental ill health led to risks not being recognised and referrals not been made at an early enough stage.

- In the large majority of cases, children's social care services responded appropriately to referrals. But in some cases adult services practitioners had to make repeated referrals before children's social care decided to take action. Adult services practitioners did not consistently challenge children's social care when they were not satisfied with the response to a referral.
- In assessments where there were issues of parent or carer mental ill health professionals did not routinely approach the assessment as a shared activity between children's social workers and adult mental health practitioners, in which each professional drew on the other's expertise. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties. On the other hand, when parents or carers had drug or alcohol problems, children's social care staff and drug and alcohol services collaborated well together to develop a good understanding of the impact of adult substance misuse on children.
- In most cases seen when parents or carers had been admitted to hospital, joint working was poor in ensuring that plans for discharge took the children's needs into account. As a result, children had sometimes been returned too early to the care of parents or carers who were unable to meet their needs at that time.
- The support and intervention that children received through child protection or children in need plans led to better outcomes in the majority of cases, both in cases involving drug and alcohol problems and mental health difficulties. For some children whose lives had not improved it remained unclear how the planned support and intervention would bring about the change needed.
- In most of the long-term cases there was a history of involvement by children's social care. These cases were complex and challenging. Parents' and carers' difficulties were not easily, and sometimes never, resolved and progress was often not sustained. Cases were opened and closed, and families were supported for a time, sometimes over substantial periods and sometimes intermittently. This raised questions about the sustainability of change, and the timeliness and robustness of previous decision-making and planning.
- Inspectors identified much stronger oversight of cases involving children by managers and designated staff in drug and alcohol services than in adult mental health services. However the concept of routine joint supervision was not embedded and none of the children's and adult services practitioners had received joint supervision in the cases examined.
- Most LSCBs and senior managers did not systematically evaluate the quality of joint working through analysis of referrals and case file audits. In most local authorities it was difficult to retrieve comprehensive and accurate data about children affected by parent or carer mental ill health. Data about children affected

by drug and alcohol problems were more readily available, although they were not always used well in planning and evaluation.

- Senior and strategic managers across adult and children's services and the majority of children's services practitioners had a good grasp of learning from serious case reviews relevant to parent or carer mental ill health and drug and alcohol misuse. This had led to a number of improvements in practice. However, this learning was less well understood among adult services practitioners.

Recommendations

The government should:

- require mental health services to collect data on children whose parents or carers have mental health difficulties and report on such data nationally
- ensure that guidance on working together to safeguard children makes it clear that adult mental health services and drug and alcohol services have a responsibility to consider the needs of any child in the family or household of their patient or client, and to refer them for services or support as necessary and appropriate in line with locally agreed thresholds for intervention.

LSCBs should:

- commission audits of the quality of case work practice in joint working between adult mental health services, drug and alcohol services and children's services and use findings to drive improvements
- put structures in place for joint training and joint supervision to ensure that all children's and adult services practitioners working with families affected by mental health difficulties and/or drug and alcohol problems have a thorough understanding of the impact of these difficulties on children and the opportunity to reflect together on their joint responsibilities in tackling concerns.

Adult mental health services should:

- increase awareness of the role of adult mental health professionals in safeguarding the children of adult service users
- review recording systems to ensure that information about children is set out clearly and in sufficient detail to establish children's needs and risks, to identify young carers and to assess whether there is a need for early support
- collate data and report to the LSCB on the numbers of children affected by adult mental health difficulties

- undertake case file audits to establish if practitioners are identifying children appropriately; considering their needs and any risks to them; arriving at sound and defensible conclusions regarding what action is needed to support or protect them; and referring them for support or intervention where necessary.
- ensure that managers are aware of all cases in which adults with mental health difficulties have children, or where there are children in the household, and that all these cases have appropriate and recorded oversight.

Commissioners of adult mental health services should:

- ensure that the role of adult mental health services in safeguarding and protecting children is set out comprehensively and explicitly in all relevant tender documents and in contracts
- have systems in place to monitor the extent to which adult mental health services meet their responsibilities to safeguard and protect children

Adult mental health services and drug and alcohol services should:

- ensure that practitioners consistently challenge decisions by children's social care to take no further action if in their judgement action is warranted, using escalation processes where necessary
- review recording systems to ensure that children and young people who are undertaking inappropriate caring responsibilities for parents or siblings are identified, and that their needs are explicitly considered and referred for support when necessary
- ensure that adult assessments consider the need for early support for parents, carers and children and that action is taken to put this in place.

Local authorities, mental health services and drug and alcohol services should:

- ensure that staff liaise with each other and agree a joint plan of action when parents or carers do not attend appointments with adult services.

Local authorities and mental health services should:

- improve the quality of assessments of the impact of mental health difficulties on children, ensuring that children's social workers and adult mental health practitioners work together to assess and agree effective action plans
- review arrangements for discharging patients from hospitals to ensure that discharge meetings involve children's social workers where appropriate; that the needs of the children are considered and that discharge plans set out clearly when/if parents or carers will be ready to resume the care of their children.

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Introduction

1. Mental health difficulties and substance misuse problems affect a significant proportion of the adult population. At any one time it is estimated that as many as 9 million adults – 1 in 6 of the population – experience mental ill health. Around 630,000 adults are estimated to be in contact with specialised mental health services.[1] Data are not collected nationally about how many of the adults receiving specialised mental health services are parents or carers, but it is estimated that 30% of adults with mental ill health have dependent children.[2]

2. Evidence from small studies of people with mental health difficulties shows that a high proportion of adults in acute psychiatric hospital settings may be parents – at least 25% and probably substantially more, especially among young women, although shortcomings have been identified in the quality of this research.[3] Research published in 2011 by the National Society for the Prevention of Cruelty to Children (NSPCC) estimates that 144,000 babies less than 1 year old live with a parent who has a common mental health problem.[4]

3. The National Treatment Agency for Substance Abuse collects national data on the take-up of drug and alcohol services and requires local areas to report on the number of service users who are parents. It estimates that around 200,000 adults are currently receiving treatment for substance misuse problems and of these one third are parents and have children living with them, although details of the number of children are not known.[5] A recent survey of parental alcohol and drug use commissioned by 4Children reported that 8% of parents had taken illegal drugs over the past year and 7% drink alcohol every day.[6] The NSPCC's review of evidence estimates that 19,500 babies less than 1 year old

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[1] *Families affected by parental mental health difficulties*, Family Action; www.family-action.org.uk/section.aspx?id=9054.
[2] D Meltzer, *Inequalities in mental health: a systematic review*, The research findings register, Summary No.1063, Department of Health; www.dh.gov.uk/health/category/publications/.
[3] G Parker, B Beresford, S Clarke, K Gridley, R Pitman, G Spiers, K Light, *Research reviews on prevalence, detection and interventions in parental mental health and child welfare: Summary report*, Social Policy Research Unit, York University, 2008; http://php.york.ac.uk/inst/spru/pubs/1125/.
[4] C Cuthbert, G Rayns, K Stanley, *All babies count, prevention and protection for vulnerable babies: a review of the evidence*, National Society for the Prevention of Cruelty to Children, 2011;. www.nspcc.org.uk/inform/resourcesforprofessionals/underones/all_babies_count_wda85568.html.
[5] *Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services*, National Treatment Agency for Substance Misuse, supported by Department for Education, 2011; www.nta.nhs.uk/publications.aspx.
[6] *Over the limit. The truth about families and alcohol,* 4Children, 2012; www.4children.org.uk/Resources/Detail/Over-the-Limit.

are living with a parent who has used Class A drugs in the last year; 93,500 babies less than 1 year old live with a parent who is a problem drinker.[7]

4. The extent to which these difficulties impact on parenting capacity varies enormously. Research shows that the impact can be mitigated by a second parent, or care by extended family involvement and early community support.[8] However, without this support children may be neglected and/or emotionally harmed. Alcohol misuse by parents, particularly by fathers, can also result in violence and risks of physical harm to children. Analyses by Ofsted of serious case reviews between 2007 and 2011 where children had either died or been seriously harmed, showed that mental health difficulties, drug and alcohol problems and domestic abuse were the most common characteristics of the families involved.[9]

5. The Children Act 2004 places a duty on partners to safeguard and promote the welfare of children, and current statutory guidance sets clear and explicit expectations that adult and children's services should work cooperatively together to safeguard and promote the welfare of children.[10] The Children Act 1989 defines children 'in need' under section 17 as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services. If children's parents or carers have serious mental health difficulties and /or drug or alcohol problems then consideration needs to be given as to how and whether this will affect their ability to care for their children, to determine if the children are 'in need'.[11]

6. However, historically, joint working between adult and children's services has not been strong. The issues, challenges and barriers to effective cooperation are well documented in inspections, research and serious case reviews. Reports by Ofsted of serious case reviews from 1 April 2007 to 31 March 2011 highlighted repeated examples of ways in which the risks resulting from the parents' own needs were underestimated – including when parents had mental health difficulties and/or drug and alcohol problems.[12]

7. Over recent years increasing attention has been given to promoting the responsibilities of all professionals to safeguard and protect children. The previous government's Families at Risk review, *Think family: improving the life*

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[7] C Cuthbert, G Rayns, K Stanley, *All babies count, prevention and protection for vulnerable babies: a review of the evidence*, National Society for the Prevention of Cruelty to Children, 2011; www.nspcc.org.uk/inform/resourcesforprofessionals/underones/all_babies_count_wda85568.html.

[8] E Sawyer and S Burton, *Building resilience in families under stress,* National Children's Bureau, 2012; www.ncb.org.uk/resources/publications.

[9] *Ages of concern: learning lessons from serious case reviews* (110080), Ofsted, 2011; www.ofsted.gov.uk/resources/110080.

[10] Children Act 2004 sections 10 and 11; www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1

[11] Children Act 1989 section 17(10); www.opsi.gov.uk/acts/acts1989/ukpga_19890041_en_1.

[12] Ofsted publications: www.ofsted.gov.uk/resources/results/serious%20case%20reviews.

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chances of families at risk sets out plans to support families experiencing the most entrenched problems – including substance misuse and poor mental health – to reduce the impact that this has on their children.[13] The 'Think child, think parent, think family' approach was developed by the Social Care Institute for Excellence in 2009 (updated December 2011).[14] A draft memorandum of understanding, *Working together to support young carers and their families* has been developed by the Association of Directors of Adult Social Services (ADASS), The Association of Directors of Children's Services and the Children's Society and has been promoted by the Department for Education.[15]

8. The national drug strategy promotes the 'Think family: improving the life chances of families at risk' approach and the importance of having effective joint local protocols between drug and alcohol partnerships and children and family services; and this has been strongly promoted by the National Treatment Agency for Substance Abuse. However, within mental health services, while individual local areas have promoted some of these same approaches and indeed piloted programmes in some instances, awareness of the 'Think family: improving the life chances of families at risk' approach has not had strong national leadership.

9. Research and guidance for practitioners, to help them support parenting more effectively in families affected by parental substance misuse or mental health difficulties, highlight the importance of understanding the day-to-day life of children and family members and building up trusting relationships with children and parents.[16] This is echoed in Professor Eileen Munro's review of child protection.[17]

Methodology

10. This report summarises the findings of a joint thematic inspection by Ofsted and the Care Quality Commission, exploring the effectiveness of joint working

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[13] Think family: improving the life chances of families at risk, Cabinet Office, 2008; www.scie-socialcareonline.org.uk/profile.asp?guid=16581919-408b-4b7c-9831-1c41e042be5f.
[14] *Think child, think parent, think family*, Social Care Institute for Excellence, 2012; www.scie.org.uk/publications/ataglance/ataglance09.asp.
[15] *Working together to support young carers and their families, a template for a local memorandum of understanding between Statutory Directors for Children's Services and Adult Social Services*, The Children's Society, 2012; www.adcs.org.uk/publications/position-statements.html.
[16] E Sawyer and S Burton, *Building resilience in families under stress,*
National Children's Bureau, 2012; www.ncb.org.uk/resources/publications.
K Crowther and G Cowen, *Effective relationships with vulnerable parents to improve outcomes for children and young people: final study report,*, Action for Children, 2011; www.actionforchildren.org.uk/policy-research/research/effective-relationships-with-vulnerable-parents-to-improve-outcomes-for-children-and-young-people-report.
[17] *The Munro review of child protection: final report – a child centred system,* Department for Education, 2011; www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208062.

between adult mental health services, drug and alcohol services and children's services to improve the identification of children whose parents or carers have these difficulties and in order that the children are supported and protected. Inspectors jointly visited nine local authority areas. The areas varied in size and geographical context and included metropolitan areas and counties of varying size, with a combination of rural and urban features.

11. Services for adults with serious mental ill health are provided through the NHS by multi-disciplinary community-based teams of psychiatric nurses, and psychiatrists and social workers. Services for adults with drug and alcohol problems are provided by a combination of treatment services delivered through the NHS, and support services commissioned from a wide range of voluntary sector providers.

12. In each area inspectors jointly examined case records with practitioners and/or managers from both adult and children's services. Altogether 105 case records were sampled, examining different key stages of work in both adult services and children's services, from referrals, assessments and joint working on long-term child in need and child protection cases. Each case was looked at from both the perspective of the adult service and the children's service to understand the contribution that each made and how they worked together.

13. Inspectors met with seven children and 14 parents or carers. In each area they also met with a multi-agency group of senior managers and commissioners, a multi-agency group of front line practitioners from adult mental health and drug and alcohol services, and a multi-agency group of front line practitioners from children's services.

14. In a number of cases, children were found to be at continued risk of significant harm. In all these incidences inspectors brought the cases to the attention of senior managers within the local authority and were satisfied that appropriate actions were then taken to protect children.

Information gathered about children by adult services

Overall

15. Drug and alcohol services were much more consistent than adult mental health services in seeking to identify whether adults using their services were parents and/or had children living with them. They also gave better consideration to the impact of the adult difficulties on the child. Underlying this stronger focus on children is the fact that drug and alcohol services have to report on the number of households with children, and the number of pregnant service users, to the National Treatment Agency for Substance Abuse and to local commissioners. Systems were established to gather the information to meet this requirement. In mental health services on the other hand, there is no requirement to gather information and report on the number of adults with serious mental health difficulties who are parents. As a result, there is much more inconsistency in

mental health services in identifying and thinking about the needs of, and risks to, children.

Mental health services

16. Mental health services use the care programme approach to record the details, assessments and plans of their service users. This approach has been adapted and developed in different ways across the country but there is an expectation that recording systems should always include questions about children to prompt adult services practitioners to consider their needs. Despite this, it was difficult to determine easily from most mental health records if there were children in the household or if the adult with the mental health difficulties was a parent or a carer or in contact with children. There was no alert or flag system in recording systems to highlight when children were present in a household, although sometimes systems highlighted when children were subjects of child protection plans.

17. Referral forms to mental health services did not consistently include questions regarding children, which on initial referral would prompt practitioners to consider whether the service user had children. Assessment recording systems in adult mental health services always included questions relating to children. However the clarity and detail of the questions varied greatly between different areas and were too limited in the large majority of areas. Household composition was often not clearly set out.

18. The best assessment systems contained clear and appropriate questions to identify whether the service user was a parent; if the children were living with them in the same household and if not whether they were in contact with them; if there were other children in the household and who else lived in the household. Tick lists were used to prompt staff to consider needs and risks for children, with space to record analysis and conclusions as to why a child of the service user was, or was not, considered to be in need or at risk.

19. Questions relating to child protection were primarily based on completing tick boxes and staff were not always asked to include the reasons for the presence or absence of risk. For example, one system asked the practitioner to score safeguarding risks, but no information was provided to support the scores.

20. However, it was not mandatory in any of the systems to complete the questions relating to children. The extent to which adult mental health practitioners answered questions and used prompts in recording systems to identify children and begin to consider their needs varied. To some extent this was due to shortcomings in the systems, but in some cases practitioners had just not completed relevant questions relating to children. This meant it was unclear if there was a child in the household or whether the question had not been asked.

Drug and alcohol services

21. In almost all areas clear and generally comprehensive systems were in place to identify when adults who had drug or alcohol problems were parents or carers, either living with, or in contact with children. For the most part detailed and appropriate questions regarding children were included both in referral templates and in the assessment tools.

22. Initial questions to identify children were completed consistently in almost all drug and alcohol services. In the majority of areas the comprehensive assessment tools were completed well, and considered effectively the likely impact of the parents' or carer's problems on the day-to-day care of the child. In one area there was no real evidence of routine consideration of children's needs when adults presented for support with their drug or alcohol problems and in two areas the extent of the consideration was more variable. In the best case records, cases clearly showed if the adult was a parent or had caring responsibilities. Records in these cases outlined:

- details of children living in the household, including any children who had overnight contact
- who else lived in the household
- the contact that the children had with the other parent, if that parent was not in the household
- the location where the parent misused drugs and alcohol
- care arrangements while the parent misused drugs and alcohol
- whether anyone else who misused drugs or alcohol lived in the home
- whether the mother was pregnant
- whether the parent had difficulties in providing care for the children
- whether children's social care services were involved.

Identifying young carers

23. Overall, insufficient attention and consideration were given to identifying if children and young people might be acting as young carers for their parents, carers or siblings. The large majority of assessments in adult services where adults were parents of older children did not explore if the children had taken on inappropriate caring responsibilities for their parents or carers. Many adult services assessment tools, in both mental health and in drug and alcohol services, did not ask practitioners explicitly to consider if children and young people were young carers. Even where there were explicit questions regarding young carers these were not always answered.

24. In the small number of cases where questions about children's caring responsibilities were asked, this did not always lead to action. For example:

> Records showed that two older boys moved from their relatives' care back to their mother to try and prevent her from drinking; however, this did not trigger a discussion about taking on inappropriate caring responsibilities and no additional action was taken or support provided to tackle this.

25. Another case illustrated the challenges of exploring the role that children take in caring for mentally ill parents and gives some insight into why this issue is not tackled more proactively and explicitly:

> In this case the mother was a single parent with two children of primary school age. The mother had delusional thoughts that she and the children were being followed and watched. She shared these fears with the children, claiming that the children were the only witnesses to her being followed. The practitioner had immediate concerns about the children and referred these appropriately to children's social care. The mental health practitioner was aware that the children might have taken on caring responsibilities for their mother but felt she had to be careful not to alienate the mother. When the mother said that the children did not have caring responsibilities she did want 'to press this further'.

When children were identified appropriately as young carers, they were referred for a carers' assessment and support was identified.

The contribution by adult services to early support for children

26. Most adult mental health and drug and alcohol services were not proactive in helping families to access early support. Inspectors saw cases in which early support, for example from children's centres and parenting advice and support, would have been useful, but there was limited evidence of adult practitioners thinking about this early in their involvement.

27. Most adult services staff had no experience of involvement in early support work through the Common Assessment Framework and Team Around the Child/Team Around the Family. In a few areas, drug and alcohol services had undertaken work to promote involvement in early support. One area, for example, had included in its joint working protocol a requirement that all commissioned services consider contact with a Common Assessment Framework coordinator when a substance misusing parent was identified. However this was not carried out consistently. Good practice was seen in a few cases. For example, in one case the drugs support worker referred a young person to their school pastoral support service; in another case a mental health practitioner linked the mother to her local children's centre and in yet another, a child was referred for play therapy.

28. Adult services practitioners were more likely to think about whether the family needed early support if a question on early support was included in the assessment tool.

29. Adult services staff were often unclear where they might refer a family to for early support. Adult services practitioners were more likely to refer families for early support where clear systems to access early support were in place and they understood the process. In a number of areas, multi-agency early intervention panels had been put in place to promote timely early support and representatives from adult services took part in them. This helped to raise awareness of early support among adult services.

30. One area was piloting a 'whole family' assessment to replace the Common Assessment Framework, which involved both adult services and children's workers undertaking joint assessments. Early qualitative feedback from families and professionals was positive, although it was too early to evidence the impact overall.

Referring concerns to children's social care services

Overall

31. Clear guidance on thresholds for responding to concerns about children was in place in all areas. Local authorities had worked hard with partner agencies to ensure that these were widely disseminated and understood.

Mental health services

32. The majority of managers were clear about the guidance available to help adult services staff understand the point at which they should refer a concern about a child and /or the parenting capacity of their parent(s) to children's social care. However, in three areas managers did not seem to know what guidance was available or where they might find it and displayed limited understanding of the concept of thresholds for children's social care.

33. Mental health services generally made appropriate and prompt referrals to children's social care when they identified that children were in the household and they had specific concerns about their welfare. Most related to concerns about the impact of parents' or carers' mental ill health on the children. Referrals generally provided clear details of the concerns and recognised risks to the children. The best referrals contained detailed information about how the parent's or carer's mental health difficulties affected their mood and day-to-day behaviour and outlined how that affected the quality of care they were able to provide and the impact on the children. Concerns often related to the parent's instability and volatility and their ability to provide consistency and put their child's needs first. Some concerns related to physical or sexual abuse not involving the parent with the mental health illness.

34. In almost a quarter of cases referred, concerns were not identified at an early enough stage, even though there were sufficient signs to indicate that the children's welfare was, or was likely to be, affected by their parent's or carer's mental health difficulty. In these cases a lack of focus on the children and a lack of reflection on, and analysis of, the impact of the parental mental ill health led to risks not being recognised early enough. The issues in these cases were serious. Examples of cases included the following:

A mother with a history of anxiety and depression. Her mental health deteriorated after her partner left the household and the GP referred her to adult mental health services. The assessment completed by the mental health practitioner identified that the mother had not showered for six months, rarely left the house and spent most of the day asleep. Food was available in the house but the mother did not cook regular meals. The assessment noted that the mother had two children, aged eight and 10 living with her but identified no risks to them. A referral was made some three months later but this was precipitated by the mother's admission to hospital.

A mother with schizophrenia who had two young children had a history of admissions to hospital. The assessment completed by the crisis team undertaken when the mother's mental health began to deteriorate identified that there were two children in the household, but did not consider their needs further. In this case the referral to children's social care was triggered later by allegations by the mother that the father had physically abused the children.

In another case it was recorded that the children were hiding the mother's razor blades to stop her self-harming. The impact of this on the children was not considered and no safeguarding issues were identified when the mother was first assessed by mental health services. The referral to children's social care was triggered by subsequent allegations of sexual abuse against the father.

Drug and alcohol services

35. Drug and alcohol services consistently made timely and appropriate referrals when concerns reached the threshold for children's social care intervention. In most cases referrals set out concerns clearly, reflecting good insight into the impact of parental substance misuse on the children. Information was included on the adult's previous history of drug and/or alcohol misuse and any previous concerns. Almost all cases involving concerns about drug and alcohol misuse were referred without delay. But in a few cases referral information was too limited to easily see the extent of the concerns. For example, in one case a referral was made because a mother had driven her children in a car while under the influence of alcohol. The referral contained details of this incident but

provided no additional information about the extent of the mother's alcohol problem or the home circumstances.

The response to concerns

Overall

36. In the large majority of cases children's social care services' initial response to concerns was appropriate. In these cases concerns were promptly followed up and assessments were undertaken.

37. But in over one in five cases referred by adult services, children's services made the initial decision to take no further action even though the level of concern was such that action should have been taken. In half of these cases, adult services practitioners had to make repeated referrals before children's social care decided to take action. In some cases it was evident that the concerns of the adult services practitioners had not been given enough weight or sometimes the level of concerns had not been conveyed clearly enough. Often, communication with the adult services regarding decisions and actions was poor. In a few areas there were good examples of referrals being robustly followed up by adult services if feedback on outcomes was not received; and there were some good examples of robust discussion between adult services and children's practitioners in cases where adult services were unhappy about the decisions made or actions not taken. One adult services practitioner said:

> 'We keep knocking on the door until we get what we need... It takes time and effort – sometimes it's about knowing who to speak to.'

38. However, adult services did not consistently challenge decisions they were unhappy with. While staff were generally aware that there were escalation processes in place, these processes were not used in the cases examined even when adult services remained unhappy with the decisions made.

Do children's services recognise when parents or carers need specialist assessment and support with mental health difficulties and/or drug and alcohol problems?

39. It was rare for children's services to make direct referrals to adult services. Referrals to mental health services were usually made via the GP or other health professionals, while adults usually self-referred to drug and alcohol services. Children's social workers saw their role as encouraging parents to recognize that they had difficulties with which they needed help and to support them in seeking help. Inspectors saw some good examples of parents taking up services as a result. However, if parents did not refer themselves for help or failed to take up appointments, children's social workers did not usually contact the adult service to seek advice or request that they visit jointly, even in cases of repeated non-attendance at appointments. Some children's social workers said it was difficult to get any involvement or support from mental health services if the adult did not engage in treatment.

Assessments, support and intervention

Overall

40. The extent to which adult and children's services worked effectively together to assess concerns and to support and challenge parents and carers varied considerably. Overall, the quality of joint working was much stronger with drug and alcohol services than it was with mental health services. Thinking about the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services.

41. When children received support and intervention as children in need or were subjects of child protection plans this made a difference to their lives and outcomes for them improved in the majority of cases, with evident improvements in day-to-day care. However, less attention was paid to the emotional impact of their parents' or carers' difficulties on the children.

42. Most long-term cases examined had a history of involvement by children's social care. These cases were complex and challenging. Parents' and carers' difficulties were not easily, and sometimes never, resolvable and progress was often not sustained. Cases were opened and closed, families were supported for a time, sometimes over substantial periods and sometimes intermittently. Cases moved between different levels of intervention from child in need to child protection and in and out of care proceedings. Children moved between parents, relatives and foster carers then back to parents. Some improvements were made and then cases were closed to children's social care. When changes were not sustained and concerns escalated, this triggered social care involvement again. This raised questions about the sustainability of change and the previous timeliness and robustness of decision-making and planning.

Mental health difficulties

43. The majority of assessments of children's needs, and any risks to them, did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent or carer with mental health difficulties. Assessments were not consistently seen as a shared activity between children's social workers and adult mental health practitioners in which each professional drew on the other's expertise. One children's social worker commented that they did not expect the mental health assessment to consider the impact of the parent's difficulties on the children, stating that, 'it's down to the [child's] social worker to assess the impact'. One mental health practitioner said that he did not feel equipped to comment on the impact on the child as he had only limited contact with them. They clearly did not understand how each professional might contribute to obtaining a full picture of the impact on the child of parental mental health difficulties.

44. Assessments usually included information regarding parental mental health difficulties, provided by mental health practitioners and sometimes supported by separate reports. However, while reports and assessments set out the parent's or carer's diagnosis, clinical needs and presentation, too often there was insufficient joint analysis of the impact of these difficulties on parenting capacity or the impact of the demands of parenting on the parent's mental health condition. The following are examples of this.

> One mother had a diagnosis of severe depression with psychotic episodes. She had a history of overdoses and a suicide attempt by hanging. She had four young children. A social worker and a community psychiatric nurse (CPN) were both involved. Concerns about the mother's capacity to provide safe care escalated and an initial child protection conference was held. The assessment presented to the conference was not informed by the CPN and it did not set out the impact of the mother's mental health on her day-to-day functioning and her ability to care for the children. The impact on the children of the mother's difficulties was not made explicit.
>
> An assessment of a mother with bi-polar disorder with a new baby did not take account of how meeting the demands of caring for her baby might affect her health, even though sleep deprivation is a well-known trigger for relapse when someone has bi-polar disorder.

45. In contrast, the case below provides a good example of using the expertise of mental health professionals in assessing a new mother's ability to care for her baby.

> **Seeing the adult as a parent and thinking about the child**
>
> The mother had a history of low mood, self-harming, violence and aggression towards other adults. The mental health practitioner to whom the mother was referred for assessment had a very clear focus on parenting in her meetings with the mother. She was very alert to the impact on the baby of the mother's difficulties, sharing observations and concerns with the social worker about how the mother interacted with the baby. Attachment and bonding were well considered. The assessment was clear that the mother's long-standing mental health problems, stemming from her childhood, meant that the mother had little insight into how her behaviour, including her violence towards the baby's father, would impact on the baby.

46. Joint visits to inform assessments were not routine. Most assessments provided limited insight into the day-to-day experience of the child and there was not enough consideration of the impact of parental mental ill health on the emotional well-being of the child, both in the short and long term.

This contributed to the lack of robust planning seen in some cases, such as the following:

> A child of primary school age lived with his mother and older brother. His mother suffered from long-term depression and an eating disorder. Mental health services had supported her for over 10 years. The mother engaged well with support and some progress was seen. Nevertheless she continued to self-harm, by cutting herself or hitting herself. She had a history of taking overdoses and being admitted to hospital. Sometimes she drank alcohol which exacerbated her condition and she did not always take her medication. She was inconsistent in her parenting depending on her mood. She regularly fell out with family members and this created further stress as she relied on family support when she became unwell.
>
> This case had been known to children's services for a long time and had a history of being opened and closed as concerns for the children were raised and then abated again. Services had been provided at different threshold levels at different points: from child in need down to Common Assessment Framework, back to child in need, then up to child protection and into care proceedings, which resulted in the child being subject to a supervision order for a limited period of time. Recently, concerns for the child, which included very disturbed behaviour at school, had escalated again. He was very aggressive – shouting, kicking, screaming, crying and had to be restrained regularly by teachers. He was excluded from school for two days. As a result the case had come back into the child protection arena and the child was once more the subject of a child protection plan.The assessment recognised that the child was at significant risk of emotional harm, but the impact of the mother's mental health difficulties was not systematically examined. Protective factors were identified but it was not made explicit that the prognosis for any improvement in the mother's mental health was poor.
>
> The analysis was very limited and did not robustly set out the issue and the impact on the child, nor did it consider frankly the long-term implications in the light of the mother's illness. The extended family were relied on to care for the child when the mother was unwell but there was no detailed consideration of their capacity to provide care.

47. A common feature of many cases was the self-harming behaviour of mothers by cutting themselves or taking overdoses. The damaging impact on children exposed to this behaviour was not always recognised and assessed. Domestic abuse, sometimes by a series of male partners, was also a common feature of cases. In these cases the extent to which the mother's mental health difficulties affected her ability to recognise inappropriate partners and to protect her children was not always clearly considered. The case below is a good example of these issues being well considered.

Assessing impact

One mother had been diagnosed with personality disorders. There were concerns for the safety of her child due to physical abuse by the mother's partner, which led to the child moving under a care order to the care of a relative. The mother received intensive support from the mental health Complex Needs Service that, together with children's social care, was closely involved in assessing whether the mother was able to resume the care of her child. They provided a formal written report on the mother's general progress and on her ability to provide good enough parenting. Strengths and continuing difficulties were identified and analysed well to understand her capacity to provide adequate parenting. Risks identified included the mother's relationships with abusive partners and her erratic emotional behaviour. The potential impact of these on the child was explicit and the mother's capacity to manage and overcome them was well addressed.

48. One case demonstrated the benefits of good joint working, in managing contact between children and their mother who was a long-term patient in a psychiatric hospital.

Promoting safe contact – a good balance of needs and risks

In this case the mother had serious mental health problems and had been in hospital for over a year. The children were living with their father. Contact between the mother and her children was subject to a risk assessment, which was well informed by the mental health team. This included a detailed and clear analysis of how the mother's mental health difficulties affected her mood and her behaviour and considered how this would impact on contact sessions between her and the children, both from her perspective and the children's. The emotional impact on the children, if the mother became distressed and behaved inappropriately, was considered. Risks were well balanced with the children's need to see their mother and the benefits to them of the contact continuing.

Reflection and decisions on what actions to take were appropriate to make sure that contact was well managed to ensure the children's safety; all relevant information was clearly recorded and shared. The mental health practitioners felt very well-involved in planning and were confident that their views were heard. The social worker noted that through the security of planned and well-managed contact with their mother, the children had been able to develop a better bond with her.

49. Information about the parent's or carer's state of health was usually shared appropriately. In many cases, although not all, child protection conferences and reviews, core groups and child in need reviews were well attended by mental health practitioners. In some areas adult services practitioners said that workload problems sometimes affected their availability to attend relevant

meetings and sometimes invitations to meetings came too late for them to attend. Examples of good practice were also seen where joint home visits were undertaken and children's welfare was carefully monitored alongside the parent's or carer's mental ill health.

50. There were a number of examples of effective joint working which led to evident improvements in children's lives. Outcomes for children had improved in the majority of cases where children were the subject of child in need or child protection plans; in a small number of cases the parent or carer with the mental ill health was no longer able to care safely for their child and the children were settled with the other parent, family members or foster carers. In some cases children were well supported at home and enabled to remain with their parent. In other cases children were successfully returned home after being removed because of the level of significant harm. Where improvements had been made, history indicated that these would only be sustained with ongoing support.

51. However in a number of cases it took some time to achieve improvements. Sometimes there were delays in recognising the extent of the concerns and children were left too long with parents or carers who were unable to care safely for them. In one third of the long-term cases examined, however, there was limited or no improvement in outcomes, often despite close joint working.

52. Assessments and plans did not clearly reflect on the impact on the child when a parent's mental health deteriorated or support systems were no longer in place. This made it difficult to judge at what point action needed to be taken to ensure the child's safety and well-being.

> In one case the mother of a baby had bi-polar disorder exacerbated by drinking and not complying with her medication. The baby was made the subject of a child protection plan and the mother's partner was seen as the key protective factor. There was evidence of close communication and a good exchange of information between the children's social worker and the mental health practitioner, but when the parents' relationship broke down the ability of the mother to care safely for her baby was not effectively jointly re-assessed.
>
> Concerns continued to escalate and these were shared and discussed but did not lead to any action being taken. Eventually the mother herself recognised that she could not care safely for her child and arranged for grandparents to take over the care. In other cases it was the decision that the parent needed to be admitted to hospital that triggered arrangements for the child to be cared for elsewhere.

53. Child protection and children in need plans did not always make clear what actions were needed to minimise the impact of the parent's or carer's mental ill health on the child and the role of adult mental health services in this. Some

plans did not include any direct reference to the parent's or carer's mental ill health, even though this was the key risk factor. Some good examples were seen of a very clear focus on the impact of parental mental health difficulties in the child protection plan, and the joint working to support the parents. For example:

Linking child protection plans to the parent's plans

In this complex case involving parents with mental health difficulties with young children who were the subjects of child protection plans, an explicit link was drawn in the children's child protection plans between support for parents and outcomes for children. In addition, relevant elements of the child protection plan were also included in the adult mental health care plan, which provided a clear connection between the parents' and children's needs.

54. In some cases communication between the agencies was poor and the two services' case records were contradictory or did not include important information. In other cases assessments were not consistently shared and taken into account. For example, a report by a psychiatrist in which he concluded that a mother did not have a mental illness was not referred to in the social worker's assessment and the mother continued for some time to be regarded as being mentally ill, despite the doctor's diagnosis. Sometimes there were disagreements between adult and children's staff regarding the degree of risk or what steps needed to be taken, and conflicts over whose needs took priority. There were cases in which the views of mental health practitioners were marginalised but also one example in which the mental health practitioner's views were given too much weight and this resulted in a lack of sufficient challenge to the parent and insufficient focus on the child's needs.

55. In most cases seen where parents or carers had been admitted to hospital, joint working was poor in ensuring that plans for discharge took the children's needs into account. As a result, some children were returned to the care of parents or carers who were unable to meet their needs at that time and in one case children were subsequently harmed by their parent. Discharge planning meetings did not always include the children's social worker. In most of these cases there was no clear assessment or plan as to when the parent would be well enough to resume care of the children, even when the children's social worker was involved in the discharge meeting. In one case where the social worker attended the discharge meeting, records clearly set out indicators of relapse for the future and showed that appropriate consideration had been given to when the mother might be in a position to resume the care of the child. However, this information had not been considered in the previous assessment.

56. This case example highlights the negative impact on children when discharge planning is poor.

A single mother of two children had a serious psychotic episode and was admitted to hospital. The children were cared for by relatives but returned to their mother's care almost immediately after her discharge, without an assessment of her parenting capacity in the light of her mental ill health. There appeared to be an implicit assumption that if the parent or carer was well enough to return home then they were well enough to resume the care of their children. Subsequent events showed that this was the wrong decision. Concerns escalated again for the mother's mental health, she was hospitalised and the children were placed with foster carers as the relatives were unable to care for them.

Drug and alcohol problems

57. In the majority of assessments, drug and alcohol services and children's social care staff collaborated well to develop a good understanding of the impact of adult substance misuse on children. Drug and alcohol practitioners showed good awareness of the needs of children and, for the most part, were keenly aware of their responsibilities to work closely with children's social workers and contribute to assessments of needs and risks for children. For example:

Sharing information – the basis of a good assessment

A three-year-old child was cared for by his grandmother. His mother was in prison due to crimes committed to fund her drug misuse. On her release from prison she moved to live with her child and the child's grandmother. The mother had become drug free in prison and wanted to take on the care of her child. She was receiving support from the drug services to tackle her addiction.

The assessment was comprehensive and well informed by the drug service practitioner, the prison and probation service. It set out the mother's offending history and how this related to her drug use. It outlined risks of domestic abuse from her partner and analysed the mother's ability to protect her child. Agencies worked very closely together in assessing the mother's ability and commitment to remain drug free. Work was done with the grandmother to assist her knowledge in identifying relapse.

Information was shared and discussed at regular core group meetings which the mother and the grandmother attended and this served to engender an open and transparent working relationship between agencies and the family.

58. Good consideration was given to parents' or carers' ability to provide appropriate day-to-day care, but in some assessments there was a lack of

sufficient attention to the emotional impact on children of parental drug and alcohol misuse. Where assessments had not taken sufficient account of the impact of parental substance misuse this was due to poor communication between agencies and a lack of sufficient focus on the child. Sometimes practitioners struggled to recognise the impact of poor parenting on attachment and children's development. In a few cases there were delays in recognising that the parent was receiving a drug or alcohol service, or that children's services were involved, leading to delays in effective joint working.

59. Joint working between drug and alcohol services and children's services on longer-term cases was generally effective. Many excellent examples of joint working were seen. The large majority of plans included a strong focus on what needed to be achieved to help address the parental substance misuse problems and the role of drug and alcohol services in this. There were good examples of the ways in which drug and alcohol services helped to develop plans that were realistic and could be sustained by parents, avoiding continued short-term interventions.

Realistic plans based on careful assesment

One mother had a long history of alcohol misuse; there were increasing concerns about her ability to care for her eight-year-old child and a pattern of improvements made but not sustained. In this case a very close working relationship between children's and adult services had a marked impact on the assessment and subsequent planning. The alcohol service encouraged a clearer focus on the long-term needs of the mother, to support her to address the underlying causes and triggers for alcohol use, while balancing this with the need of the child for appropriate care.

Together they agreed a plan for the family with a shift in focus away from the requirement for the mother to achieve complete abstinence.The social worker described the plan as 'not being driven by one agency' and explained how the involvement of adult services enabled her to shift her thinking in terms of what she could realistically expect from the mother, while keeping the child's needs as paramount.

The assessment and subsequent plan addressed the reality that the mother was likely to relapse into drinking but ensured that safety planning was in place so that the child would be cared for by other adults in the family when his mother relapsed. Other family members and a network of agencies working with the family were alerted to the indicators that the mother was starting to drink and it was made clear when other adults would need to step in to care for the child. The plan addressed:

The emotional impact on the child

Professionals developed a clear understanding and sound analysis of the emotional impact that the mother's drinking had on her child. He was withdrawn, anxious, had difficulty in developing peer relationships and

was aggressive to other children. He had lived in an environment that lacked boundaries and consistency and where he was constantly anxious about when his mother would start drinking.

Direct work with him by the family worker and social worker helped him address his high levels of anxiety and confusion as to his mother's behaviour.

The mother's emotional health

The mother received psychological support to help her understand the underlying causes of her alcohol dependency.

Triggers and strategies

The alcohol support practitioner worked with the mother to address the triggers for the alcohol use and worked with her to develop strategies to manage stress.

Parenting work

The social worker and family worker worked together with the mother to address issues of parenting. Her parenting was also addressed in the sessions with the alcohol support practitioner. She also attended a group work programme on the effects of alcohol misuse on children.

Close communication and regular feedback from sessions between agencies resulted in a coordinated and coherent service. This was particularly important with a parent who misused alcohol, as she was aware of this close working relationship which meant that she could not hide her drinking from professionals. The mother said:

'I feel supported and not judged and this means that I can be honest.'

Outcomes

The safety plan had worked well in that the mother was aware of when she was starting to drink and other adults had cared for the child appropriately.

The child's levels of anxiety reduced, he began to engage positively with school and develop friendships and his school performance improved. He was able to talk about his mother and there was more openness and honesty in the family about the mother's problem and adults in the family.

The mother's drinking had reduced. The plan meant that the mother did not have to hide episodes of relapse from professionals and this led to a more open and honest working relationship with all agencies so that the mother was no longer minimising her drinking problems. This had

positively impacted on her ability to engage on a long-term basis with adult services. The mother no longer saw relapse as a complete failure.

The outcome of direct work with the child was fed back to the mother by the social worker and addressed in sessions by the adult worker. This had a very real impact on the mother as she came to realise the full impact of her pattern of using alcohol on her child and this served to further motivate her to change her behaviour.

60. Outcomes for the large majority of children had improved in the long-term cases examined. It was clear that the current progress made in tackling the concerns was directly related to proactive and positive joint intervention and support by drug and alcohol practitioners and children's services working effectively together. However, the case histories showed difficulties in sustaining progress without ongoing support.

61. For some children, identification of concerns and thorough assessments, well-informed by the drug and alcohol services, led to children being placed with alternative carers, where they had made good progress. The contribution of the drugs and alcohol service to the assessment and ongoing work was instrumental in making sure that the concerns for the children were tackled robustly and in a way that had not happened previously. For example:

'Getting a grip' on planning for a child's future

A three-year-old child had been known to children's social care since birth. The mother had a long history of alcohol misuse, domestic violence and attachment difficulties. Following a core assessment, a range of support was put in place using the health visitor, a nursery and a children's centre; the case was closed to children's services. There were repeated referrals of concern and further assessments which led to no further action. It was not until the drug and alcohol service became involved that the impact of the mother's alcohol use on her child was properly assessed, clearly described and analysed. Through close and effective joint working between the children's social worker and the alcohol support practitioner a clear focus on the child's needs and their experiences was maintained. This led to the child being removed from the parent's care and placed with relatives. The case is currently in public law proceedings.

62. In a number of cases, because of strong challenges concerning the impact of their lifestyle on their children, and sustained support, parents and carers had managed to get to grips with their addiction and were providing safe and secure care for their children. Sometimes the knowledge that they were at real risk of losing the care of their children galvanised parents to tackle their addiction.

63. For some children outcomes had not improved and plans were not sufficiently outcome-focused to support change. For example:

> A child and his baby sister lived with a parent with a drug misuse problem. There were long-term concerns about neglect and lack of supervision. The assessment had not spelt out the nature and extent of the harm and risk experienced by the children. The children's experience of life at home was not clear. The plan was focused on activity and compliance; it described how services were to be provided, but was less clear about what the barriers to changes were and how these could be overcome.

Multiple problems

64. In some cases parents or carers had both mental health difficulties and substance misuse problems and both adult services were involved. Domestic abuse was also a common feature in many cases. One area had developed a multi-agency team, which included adult services and children's practitioners with expertise across mental health, substance misuse, domestic abuse and child protection, to tackle this more effectively.

> **Making joint working a reality**
>
> **Middlesbrough City Council and Tees, Esk and Wear Valleys NHS Foundation Trust – The Families Forward team**
>
> The team includes: a specialist alcohol social worker; children's social workers; adult social workers with specialist expertise in mental health and substance misuse; a public health nurse; family support workers; and a part-time clinical psychologist. It works with families who have reached a point of crisis as a result of parents having problems with substance misuse, domestic violence and/or mental health that are directly impacting on the well-being of their children.
>
> The team provides a family assessment programme which consists of three phases of intervention: intensive family intervention where a team sets goals with the family to bring about sustainable change in family functioning; family support to enable parents to develop new skills and build on strengths; and a maintenance programme to ensure that positive changes are sustained. The Families Forward team offers a planned and comprehensive approach to joint working that provides a time-limited holistic package of support to ensure that parents and carers sustain the necessary changes for them to provide good enough care to their children.

The views of parents and carers

65. Parents and carers who met with inspectors felt generally well-supported by most, although not always all, the services and practitioners working with them. Parents and their children were usually involved with a wide range of services and came into contact with a large number of practitioners. Most were clear about practitioners' different roles and thought that communication between the different agencies was good. They knew that concerns were shared openly. Parents and carers provided valuable insights into what they found useful and also what difficulties they had encountered.

66. Key positives were:

- workers who were easily accessible and responded quickly
- having the same people supporting them over a period of time: 'Having the same people has been really important. I trust them.'
- support from people who are supportive, non-judgemental but honest, 'Who tell me like it is.'
- relief from stress by having people to provide 'a sounding board'
- advice and support around parenting
- direct work with children to help them understand their parents' mental illness
- meeting with workers at convenient local venues
- support with relapse prevention
- help to understand the underlying reasons for addiction
- practical help in sorting out housing.

67. Key negatives were:

- workers who had a 'tick box' culture and who did not provide sustained support
- difficulties in getting to see a psychiatrist without 'seeing lots of nurses first'
- a lot of changes of children's social workers.

68. Two parents were very critical of the joint working between services. One parent said that mental health and children's services could work better together if they 'saw my family and me as a whole rather than each service addressing different aspects of our problems'.

Views of children

69. The children were able to talk about the people who helped them, primarily social workers, family support workers, school nurses, mentors and a young

carers' project. The children liked the time that people spent with them, sometimes doing activities and sometimes having the opportunity to talk. One child said:

> 'We draw pictures and talk. They talk to us about things that make us worried and help to make it better.'

Another said:

> 'The social worker is very kind and helps to talk about hard things.'

One young person explained how the family support worker helped to put routines in place and worked with all the family using charts so that they could stick to agreed routines, such as getting ready for school. Some of the children knew that their parent had a community psychiatric nurse that visited them at home. One child said:

> 'She talks to mum and that makes our life better.'

Knowing who to contact to get support was very important for the children.

70. While all the children felt that the support they got helped, they also talked about things that did not always go so well; this included having social workers they liked leave, and different workers not talking to each other or giving each other inaccurate information. One young person said she would like to meet with other young people whose mothers have the same problems as she felt this would help her.

Understanding, training and support

71. Most children's and adult services practitioners felt they had a good understanding of the impact of parental mental ill health and substance misuse on children and felt confident in working with families where these were issues. However this understanding was not consistently evident in the cases examined. The staff that inspectors met with generally felt well supported; they said that they had good access to advice and guidance to discuss any concerns they had at an early stage. These resources included their managers and named safeguarding professionals as well as their designated professionals.

72. Records showed much stronger oversight of cases involving children by managers and designated staff in drug and alcohol services than in mental health services. Records examined showed that oversight and advice were sought from managers and designated staff in drug and alcohol services in the large majority of cases, while this was evident in only a small minority of cases in mental health services. The concept of routine joint supervision with the children's and adult services practitioners was not embedded and none of the

practitioners had received joint supervision in the cases examined for this inspection.

73. Reports were made to LSCBs on the number of staff attending various safeguarding training events. The proportion of staff who had undertaken training at the right level was rigorously scrutinised through LSCB training sub-groups in many areas, but training information and analysis were more limited in other areas. In some areas there was a lack of clarity among children's practitioners about which training courses were mandatory. As a result not all LSCBs had a clear overview of whether training was targeted appropriately and was reaching the right people.

74. Safeguarding training is mandatory for mental health practitioners and take-up is monitored and reported on within health Trusts. Mental health practitioners usually took up training within their Trusts or organisations. Most health Trusts offered an appropriate range of safeguarding training, though in one area the level of training on offer was limited, with many staff only having access to a basic half-day training course that made them aware of relevant policies and procedures. In many areas there was increasing reliance on e-learning, which limited opportunities for shared reflection and discussion.

75. Adult mental health services managers and practitioners had undertaken training on safeguarding at various levels. However, some were not clear about the level of training they had received or what the expectations were. Mental health practitioners should receive comprehensive safeguarding training at level 3, but only two of the managers interviewed had undertaken training at this level. This is likely to have contributed to a lack of sufficient focus on their role in safeguarding children.

76. Safeguarding training is a mandatory requirement for drug and alcohol practitioners. It is included in contracts and take-up is monitored and reported. Managers and practitioners in drug and alcohol services had all received training on safeguarding. Most were clear about what training they had undertaken and should undertake. Most had attended a combination of in-house training provided through their own agency and specific courses provided by the LSCBs about the impact of parental substance misuse on children. Many providers were involved in delivering training to children's services staff. In four areas managers had attended training on the Common Assessment Framework.

77. Training about the impact of mental health difficulties and substance misuse on parenting was provided by the LSCB in most areas and was open to both adult services and children's practitioners. Where this was not provided this was a serious omission. Children's social workers reported generally good access to this training, but the take-up by adult services practitioners, particularly mental health practitioners, was low. This limited opportunities for joint reflection.

In one area there was a good example of an LSCB taking action to tackle this:

Nottinghamshire LSCB

The LSCB ran a specific course called 'Trilogy of Risk' which focused on parental mental health, substance and alcohol misuse, and domestic abuse. An analysis of attendance showed that attendance by adult services practitioners was decreasing. The issue was discussed at the LSCB training sub-committee and raised with the LSCB board. As a result, subsequent training was targeted to ensure more balanced attendance by adult services and children's services staff**.**

78. Some practitioners felt that the LSCB courses were pitched at too low a level and were primarily aimed at awareness, rather than the challenges of joint working with parents with very complex needs.

79. While joint supervision had not taken place on any of the cases examined by inspectors, a number of different services across areas offered opportunities for joint reflection and case-based supervision, and invited practitioners from both adult services and children's services to these sessions. Mental health practitioners, including psychiatrists and psychologists shared their expertise with children's staff: for example in working with parents with personality disorders and in managing non-engaging or challenging parents through seminars and regular workshops. Drug and alcohol services often provided tailor-made training for children's teams.

80. There was a strong consensus about the benefits that joint training brought in terms of mutual understanding and shared accountability. Many practitioners said they would value the opportunity for more joint training using case scenarios and reflective practice. Drug and alcohol practitioners take up more opportunities for joint training and many had undertaken specific training on 'Hidden harm' and 'Think Family'. Most mental health practitioners and drug and alcohol staff had not undertaken Common Assessment Framework training. Sometimes the full range of joint training opportunities was not shared and coordinated to enable access to a wider range of practitioners.

81. In many areas additional steps had been taken by adult mental health teams and drug and alcohol teams to ensure a better understanding of safeguarding children and this had led to an improved focus on children. Examples included:

- identifying safeguarding leads in teams responsible for raising and maintaining awareness of safeguarding and child protection
- shadowing children's services staff in duty and assessment teams
- regular whole-team training on safeguarding and child protection, including opportunities for reflective practice discussion about cases.

82. In most areas children's services staff said they had ready access to advice from adult services, although sometimes this was based on known networks and professionals rather than a more formal system. One social worker said:

> 'It's very much about who you know rather than there being clear pathways to get advice.'

83. In some areas drug and alcohol practitioners had been linked to specific children's teams and this was seen as very helpful to effective joint working.

84. Similarly, adult services staff have ready access to advice from children's services staff**,** usually by contacting duty or referral and assessment teams. In a number of areas staff said that having students on placements from children's/adult services helped to develop mutual understanding and trust.

Overview and evaluation

Joint working strategies, protocols and planning

85. Of the nine areas, three had developed 'Think Family' strategies while the remaining six had invested to varying degrees in developing and embedding a 'Think Family' approach. In some areas this was still at an early stage. There were a number of examples of how this had resulted in changed practice and better outcomes. For example, in one area, work on a 'Think Family' approach had led to a greater emphasis on the importance of early decision-making for young children.

Bolton City Council – making tough decisions early

Identifying children at risk of significant harm from parental substance misuse or serious mental ill health led to a strong focus on the need to make tough decisions at an early stage, when children were still young. The strategy is to intervene early, clearly identify those who are safe to remain at home with support and those who are not, and whose parents are not able to make the necessary changes.

This has led to a shift in the age profile of children becoming looked after to a much younger age, and a marked increase in the numbers of children with adoption plans.

86. Almost all areas could point to protocols they had developed or initiatives they had introduced aimed at improving joint working across children's and adult services. In some areas these sprang directly from a well-developed 'Think Family' strategy, as in the example outlined below.

Islington Borough Council and Camden and Islington NHS Foundation Trust

Joint-funded liaison posts

A mental health social worker and a substance misuse social worker were based in children's services and were used as sources of advice and guidance by both adult and children's services. This helped a good mutual understanding of thresholds for each service and gave practitioners confidence about when to make referrals and what response they might expect to receive. One liaison worker was described as a 'fountain of knowledge'.

Targeted childcare

Parents with mental health or substance misuse issues are able to access pre-school support for their children through the priority panel for childcare. Children under three years can be supported for up to 15 hours a week to enable parents to attend treatment. This provision was valued by front line practitioners.

87. In some places where a 'Think Family' strategy had been developed, it was difficult to see the impact of this on improving the quality and impact of joint working in practice. When strategies were underpinned by implementation plans with clear lines of responsibility, outcome-focused targets and actions, monitoring and reporting, there was evidence of impact, as in the following example.

Oxfordshire County Council and Oxfordshire NHS Primary Care Trust (PCT)

'Think Family' work in mental health services

With funding and support from both the council and the PCT, the Trust employed a 'Think Family' champion to implement a 'Think Family' strategy in the Trust. Each division identified a 'Think Family' lead and a steering group was formed that oversaw the Trust action plan and local plans. These included a 'Think Family' communication plan. Actions were clear and outcomes were measurable. They included:

- an audit of inpatient psychiatric wards to establish if they were child friendly
- audits of joint working on individual cases
- audits of participation in child protection conferences.

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Barriers to good practice were identified and steps were taken to tackle areas for development arising from the audits.

'Think Family' prompts were developed and disseminated to mental health practitioners to be used in their clinical assessment

Clinical assessment questions for 'Thinking Family'

- Who else is in your family?
- Are there children in your family, living with you or somewhere else?
- Who looks after them?
- Are you happy about how they are looked after? What do other people think about this?
- How is the parental illness affecting the children?
- Who else is helping other people in the family, whatever their age?
- Do you think the children are safe? What do other people think about this?
- When the children want to talk about things who do they go to? Is that enough for them?

The appointment of a champion in the mental health trust was a key factor in driving this work.

This work is ongoing but has helped the area to have a better understanding of the quality of practice of joint working and has improved it.

88. Awareness of responsibilities to identify children and consider their needs was almost always stronger in drug and alcohol services than in mental health services. In part this was driven by the national requirement that all providers of drug and alcohol services report on the number of households with children and the number of pregnant service users to the National Treatment Agency for Substance Abuse. Systems were established to gather the information to meet this requirement. This was further strengthened by comprehensive and clear expectations on protecting children written into tenders and contracts by commissioners, with increasing awareness of the Hidden Harm agenda. Contracts with providers of drug and alcohol services included expectations regarding safeguarding and protecting children, but in most areas compliance was not monitored and verified by commissioners through case file audits.

89. Within adult mental health services, although it is expected that the care programme approach considers protection of children, there are no national requirements to gather information and report on children whose parents or carers have serious mental health difficulties. In the absence of any national drivers, scrutiny of this issue is therefore limited within mental health services generally.

90. Most areas used the information gathered locally about drug and alcohol service users to inform needs assessments and service planning. A number of areas highlighted the growing number of parents among their service users. However, it was not always clear to what extent this information was used to actively inform service planning for joint working.

91. Within mental health services the national care programme approach includes an expectation that the needs of children will be considered. However, data are not collected nationally on the number of children whose parents have serious mental ill health difficulties, and in local areas no priority is given to ensuring that children are consistently identified and considered. In local areas recording and information systems in mental health services did not enable easy identification of households where children were living with mentally ill parents or carers. Mental health services did not collate information and report on children in households and therefore there is no reliable information available to inform needs assessments and service planning for joint working.

92. The extent to which safeguarding children was included in commissioning of adult mental health services varied and was not always clear. Some areas recognised that it was not as strong as in drug and alcohol commissioning. One new commissioner said there was no reference to this in the current contract for mental health services in that area. Other areas noted that safeguarding requirements in contracts focused on expectations regarding training and supervision.

Monitoring, evaluation and quality assurance

Overall

93. Overall there was insufficient focus on evaluating the quality of joint working. A few areas had a good understanding of their strengths and areas for development, but most local authorities and their partners had not established robust systems to enable them to explore and report on this.

94. Most local authorities and partners did not analyse referrals to consider if they were received appropriately from adult mental health and drug and alcohol services. Most local authorities had great difficulty in easily identifying referrals from mental health services, and in some areas from drug and alcohol services. Mental health services were unable to identify easily which cases they had referred to children's social care services. In most areas systems did not facilitate identifying child protection and children in need cases where the parents or carers had mental health difficulties and drug and alcohol difficulties, although information on the latter was better.

95. While preparing for this inspection several areas had great difficulty in identifying those children who were receiving services who had a parent or carer with a mental health problem; as there was no collation of such data,

these areas resorted to asking individual social workers to identify cases they were currently supporting. This means that it would be impossible to assess the effectiveness of services for this cohort of children, and therefore plan services for the future.

Local Safeguarding Children Boards

96. Mental health and drug and alcohol services were well represented on LSCBs. Commissioners, and in most areas provider representatives, sat on Boards and adult services were also involved in sub-groups.

97. Most LSCBs had not commissioned audits of joint working. Where LSCBs had undertaken audits of joint working there were examples of positive outcomes, such as the following.

> An audit was undertaken of practitioners' understanding of roles and responsibilities, particularly in adult services. The outcomes from this have been used to inform the LSCB training programme.
>
> One LSCB commissioned case file audits on assessing joint working between mental health services and children's social care, and repeated this audit two years later. This showed incremental improvements in recording children's problems where parental mental health was an issue, and considerable improvement in children's social care in identifying the impact of parental mental health difficulties.

Children's services

98. Case file auditing is well established in children's services, particularly in child protection work. Audits included examination of joint working on some case files, but findings related to joint working were not routinely collated and analysed. There was some evidence of specific learning and/or improved practice emerging from audits overall, but this was limited.

Mental health services

99. Managers told inspectors that they and their staff had a good awareness of safeguarding and child protection. They were confident that staff identified and considered children when their service users were parents or carers. However, the basis of this confidence was not clear as there was no systematic approach to ensuring that practitioners had thought about children's needs. Managers expected practitioners to discuss any concerns about children with them and to raise these at clinical team meetings. In most teams managers did not have a system to identify which households had children and did not monitor referrals to children's social care.

100. Very few managers systematically audited case records to ensure that children were appropriately identified and that their needs and the risks to them were considered. Clinical audits were undertaken but these focused on compliance

with processes rather than quality, and questions on safeguarding children were not routinely included. One mental health trust had recognised this and had undertaken an audit specifically focused on safeguarding. Through this it had found that systems to identify children had not been consistently complied with, and had taken steps to improve this situation.

Drug and alcohol services

101. Most drug and alcohol services had systems in place to check if children were appropriately identified and their needs considered. The extent of these systems varied. In teams where systems were strong this meant that:

- managers had instant access to lists of cases in which children had been identified
- managers discussed all cases in which children had been identified with practitioners
- assessments were signed off by managers who checked that questions about children had been completed
- cases were risk assessed and those identified as medium and high risk had additional supervision and support from the identified safeguarding practitioner/manager.

102. Some teams had introduced systems to assist in focusing on concerns about children. In one area drug and alcohol services had introduced a child protection tracking tool which was completed when staff became concerned about a child. The manager kept a copy and it was also on the case record. One drug support team had introduced a daily 'flash' meeting. At this meeting service users who had not attended appointments when they should were discussed. This was a useful approach to help identify escalating concerns on a daily basis where there were children in the household.

103. Most managers of drug and alcohol services undertook regular audits which included a focus on safeguarding children. However, not all audits examined the quality of practice, and findings from audits were not usually collated and reported to senior management, commissioners or the LSCB. This was a missed opportunity to maintain an up-to-date picture of the quality of practice and identify trends or issues regarding joint working.

Learning from serious case reviews

104. Strategic and senior managers were very well aware of key findings from serious case reviews and could point to a range of changes and improvements to services as a result of findings from both national and local reviews. These included:

- campaigns on the dangers of co-sleeping and checks to make sure that parents had cots for babies
- the introduction of lockable storage boxes for parents who used drugs, and checks to make sure they were used
- guidance on risks presented by parents with 'command hallucinations'/those with suicidal ideation, regarding risks to children in the household
- fire safety checks and fire alarms provided by fire services
- specific work to strengthen the focus on children in adult mental health in two areas; one area had developed a tool to improve consideration of the impact of mental health on children, following a serious case review in the region.

105. The majority of children's practitioners had a good grasp of learning from serious case reviews relevant to parental mental ill health and drug and alcohol misuse. Learning was disseminated to them through emails, briefings and seminars. They could link to changes made to services as a result of findings from serious case reviews. However in four of the nine areas, children's practitioners displayed little knowledge and understanding of the key issues emerging from serious case reviews. One group commented that although they were sent links to information about findings from serious case reviews they had no time to read these and they were not followed up and discussed by managers. In most areas, adult services practitioners were much less clear about findings from relevant national or local serious case reviews.

Challenges to effective joint working

106. The general view from senior managers was that joint working had improved and adult services had a stronger focus on children. That said, a number of continuing challenges were identified:

- the lack of reliable data, particularly regarding children whose parents or carers had mental health difficulties
- ensuring that adult services staff maintain a focus on safeguarding children and have the right training and supervision to support them in a climate of huge structural and organisational change within health services
- the increasing pressure on resources in both children's and adult services from the growing number of parents with substance misuse problems.

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Conclusion

107. The extent to which adult and children's services worked effectively together to assess concerns and to support and challenge parents and carers was very variable. Overall, the quality of joint working was much stronger in drug and alcohol services than it was in mental health services. Thinking about the impact of parents' or carers' difficulties on children was more strongly embedded in drug and alcohol services than in adult mental health services. In drug and alcohol services this was supported by good recording and reporting systems, closer management oversight, case file audits and better involvement in joint training than in mental health services.

108. Once adult services recognised concerns in relation to children these were referred appropriately to children's social care services. But while drug and alcohol services usually identified concerns promptly, referrals were not always made at an early enough stage by mental health services as they had not recognised and assessed the impact of the parental mental ill health on the children.

109. The impact of parental drug and alcohol problems was generally well understood and children's services and drug and alcohol services worked closely and effectively together to assess risks.

110. The impact of parental mental ill health was not routinely considered and identified. Many mental health recording systems did not consistently capture sufficiently detailed information about children. The majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with a parent/carer with mental health difficulties; children's services and mental health services did not consistently develop assessments together. Plans did not always include direct reference to the parent's or carer's mental ill health. Sometimes there were delays in recognising the extent of the concerns and children were left too long with, or returned to parents or carers who were unable to care appropriately or safely for them.

111. Support and intervention for children through child in need or child protection plans had made a difference to improving children's lives in the majority of cases. However in most long-term cases examined there was a history of involvement by children's social care with improvements not being sustained. This raises questions about previous support and decision-making in these complex cases where parents' and carers' difficulties are not easily, and often never, resolvable.

112. Most LSCBs did not have a clear grasp of the quality of joint working practice as evaluation and auditing of this practice were not well established. Data on referrals from adult services or the number of children involved with children's services because of concerns about adult mental health difficulties or drug and

alcohol misuse problems, are not routinely analysed and are not always comprehensive or accurate.

Further information

Ofsted publications

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Think child, think parent, 'Think Family': a guide to parental mental health and child welfare, Social Care Institute for Excellence, updated December 2011; www.scie.org.uk/publications/guides/guide30/index.asp.

Working together to support young carers and their families, a template for a local memorandum of understanding between Statutory Directors for Children's Services and Adult Social Services, The Children's Society, 2012; www.adcs.org.uk/publications/position-statements.html.

Annex: Providers visited

Local authorities children’s social care services, mental health services and drug and alcohol services in:

Bolton
Devon
Dudley
Hull
Islington
Middlesbrough
Oxfordshire
Nottinghamshire
Warwickshire.