# Think Family Protocol

## Contents



## 1. Scope and Purpose of the Protocol

This protocol relates to all partner agencies within Warwickshire Safeguarding Children Board and Warwickshire Safeguarding Adults Board and has been produced to agree a common set of principles that:

- Ensures a joined up approach to families' needs;
- Ensures universal and specialist services improve the identification of children in need and in need of protection through increased understanding of the impact of an adult's problems on a child's life;

- Recognises the needs of adults as service users and parents/carers;
- Establishes clarity about respective roles and responsibilities of relevant agencies;
- Ensures good co-operation and collaborative working across organisations by agreeing and jointly owning procedures for all stages of the interaction between families and agencies from referrals to assessments, information sharing to planning, service provision to funding and review;
- Improves inter-agency communication and information sharing through the use of a common policy.

## 2. Principles Underpinning the Think Family Approach

The safety and well-being of children is paramount

All professionals who come into contact with children and their parents/carers and families and pregnant women must recognise they have a duty to safeguard and promote the welfare of children. The children's needs and safety are paramount and any concerns should be recorded and referred in line with Section 3 of the WSCB interagency child protection procedures ‘Making a Child Protection Referral’. http://www.warwickshire.gov.uk/wscb

A needs led approach provides more effective support for families and helps to prevent unnecessary problems arising.

The well-being of children and their families is best delivered through a multi-agency approach with different services working effectively together.

Assessment and subsequent work with families, needs to be made within the context of individual cultural understanding and equitable access to services.

Diversity will be valued but will not be used to provide an explanation or used to condone acts of abuse or neglect or to prevent appropriate action being taken.

Parenting capacity is best assessed with the joint input of workers from adults and children's services with support where appropriate from services with specialist expertise.

Where this is an issue for families, drug and alcohol and domestic violence services must be routinely involved in the child protection process from initial conferences through assessment and planning to provision of services.

Efforts should be made to work in partnership with families, children and significant others during referral, assessment and follow-up unless this would compromise the safety of adults/ their children/adults in need of safeguarding.

Parents, carers and children will be communicated with in a timely, appropriate and accessible manner that assists them to understand what is happening.

Children will be listened to and their wishes and feelings explored. Their views will be clearly recorded and the needs of the adults should not marginalise the needs of the children.

Additional support needs should be addressed by enabling parents/carers to access universal and community services and by the timely provision of specialist assessment services wherever possible.

Where required, access to independent advocates with the appropriate skills must be provided e.g. learning disability.

## 3. Successful Inter-Agency Working

The following underpin good working relationships and are vital to the success of the protocol

- Understanding and respecting the roles and responsibilities of each service;
- Good communication with clear channels;
- Regular contact and meeting;
- Common priorities and joint planning;

- Joint and regular training which keeps individuals up to date in developments in the field of domestic violence, mental health, drugs and alcohol and learning disabilities and their impact on child welfare;
- Knowledge of available services and contact details;
- Clear system to resolve issues;
- Good information sharing underpinned by a Joint Information Sharing Protocol;

Serious Case Reviews repeatedly show when a child is seriously injured or dies as a result of abuse or neglect, the same sort of systemic failings have been present in and between the relevant services. If these failings are to be addressed effectively and systematically the following good practice points should be followed in work with families:

- Clear information sharing at the earliest opportunity;
- Joint working between the various interagency teams involved particularly focussing on relationships within the family and joint oversight of the on-going work. This is particularly important if both parents/carers and where relevant ex partners are involved with services;
- Attempts must be made to identify if there is relevant historical evidence of previous contact with drug and alcohol/ mental health/ forensic services and police/YOT/probation services for parents/carers/partners and ex partners;
- Clarity about lines of responsibility between teams;
- Flexibility about professional boundaries so that children do not fall between services and are not left at risk;
- Vigilance about the way information is received by different service areas, i.e. clarifying concerns expressed by telephone and requesting written confirmation;
- Reducing the informality of communications between service areas so that significant assessment information is not lost or minimised by assumptions being made;

- All agencies that mainly serve adult service users must consider, when deciding if an individual meets their threshold for a service, the possible impact on the individual of any caring responsibilities for children;
- All agencies that mainly serve children and young people must consider, when deciding if the child or young person meets their threshold for a service, the possible impact on the child or young person of having a parent/carer with additional problems (for example, families affected by domestic violence, drug or alcohol misuse, parental mental ill health, parental learning difficulties or disabilities, disabled parents or parents with long term health problems or significant personality disorder). Relevant information about ex partners should also be considered;
- Each agency should have a safeguarding lead for children and some agencies will also have a safeguarding lead for adults.

## 4. Identifying the Needs of Children, Unborn Children and Families

Agencies find it difficult to provide a co-ordinated and adequate response to the minority of families who face multiple and complex problems and needs. Local professionals have consistently identified the need to find more effective ways of working across adults and children's services. This was echoed at government level by the report "Think Family: improving the life chances of families at risk" (London: Great Britain. Cabinet Office. Social Exclusion Task Force, 2008). This identifies that greater priority needs to be given to ensuring there are joint and collaborative working practices within and across agencies to respond to the increasing separation between service areas and increasing specialisms within these areas. Without this, it will be very difficult to effectively protect children, support parents and carers. Research has identified that families want services that are multi-disciplinary and which do not withdraw when the crisis is over but continue to prevent or reduce the circumstances that can result in further crisis. The most effective multi-disciplinary work retains a family focus, builds on the strengths of family members and provides support tailored to need.

This protocol aims to strengthen multi-agency working with families where one or more adults have been identified with issues which potentially put children at greater risk. These are children who:

- Have a parent/ carer with a history of domestic violence/other known violence;
- Have a parent/carer who has a psychosis;
- Have a parent/carer with a significant personality disorder;
- Have a parent/carer who misuses substances(drugs or alcohol);
- Have a parent/carer with combinations of the above such as dual diagnosis of mental illness combined with drug and alcohol abuse;
- Become targets for parental or carer hostility, aggression or rejection;
- Feature within parental/carer delusions;
- Are seriously emotionally and/or physically neglected as a result of parental or carer illness/ functioning;
- Are routinely used to meet a parent/carers own needs including fabricating or inducing illness in their children;
- Have a parent/carer who has a partner or ex-partner who fits any of the above categories.

It is important to avoid stereotyping so that individuals still feel able to approach agencies, including Social Care Services, for help, support and protection and opportunities for early intervention are not lost.

However, serious case reviews have consistently shown that the issues identified above individually or often in combination can significantly impact on the functioning of the adults and their families and increase the range and level of risks experienced. They may impact on the ability to parent and/or protect their children or unborn child. In many cases the parent/carer will face simultaneous multiple difficulties both economic and/or social. Adults in these families may themselves be adults in need of safeguarding. Consideration also needs to be given to the needs of disabled children and their families). In addition, there may be increased risks to disabled children

where there is domestic violence and some disabled children may be violent toward parents or carers.

Where there are concerns about the parent/carer's ability to provide adequate care and protection the needs of the children are paramount. The WSCB website (http://www.warwickshire.gov.uk/wscb) contains information for all professionals working with or in contact with children and young people. It gives guidance to professionals on what to do if they are concerned about a child and how to make a referral to Children's Social Care Services and in an emergency to the police. Further information on the roles and responsibilities of agencies and workers, the services that are available and the legal framework that is applicable is available within the appropriate practice guidance found via the website:

- Appendix 4: The Legal Framework
- Appendix 6: Information Sharing in Child Protection
- Appendix 11: Working with Resistant and Non-compliant Families
- Appendix 12a: Substance Using Parents and Their Children
- Appendix 12b: Substance Misuse and Pregnancy
- Appendix 13: Domestic Abuse and Child Protection;

The definition of a child in need and a child in need of protection is set out in Section 2 of the WSCB interagency child protection procedures and are supplemented by the Thresholds for Intervention document (2011).

Thresholds for Intervention.doc

## 5. Impact on Children

There is increased awareness of the impact that the problems and difficulties experienced by adult family members can have on the development and psycho-social adaptation of children. There is also national recognition that emotional abuse and in particular neglect of children is significantly under-recognised and addressed.

Parents, carers or pregnant women may have difficulties which impact on their ability to meet the needs of their children or expected child. These children may be in need of assessment for services provided by a range of agencies from universal and early intervention to acute or specialist. These questions are designed to guide your decision making when establishing the needs of the adults, children and/or unborn child:

- Are you treating, providing a service to a parent/carer, family member with a mental illness, a drug and alcohol misuse problem, a learning disability or adults who are victims or perpetrators of domestic violence?
- Do they have children?
- What are their ages?
- Is there a young carer within the family (further information about young carers can be found at www.warwickshireyoungcarers.org.uk
- Does the parent/carer/partner have very unrealistic expectations of a child e.g. expecting the child to take the emotional place of a grandparent who has recently died?
- Have you considered the impact of your patient or client's illness/ disability/ situation on their ability to meet the development and safety needs of their children and/or unborn child?
- Have you considered the impact of family functioning, family history, the wider family and environmental factors on the parents'/carers' capacity to respond to the children's/unborn child's development and safety needs?
- If your client is pregnant has she accessed ante-natal care?
- Do you think the family/pregnant woman would benefit from any additional services?
- Do you know what other services are involved and what their role is?
- Have you discussed the need for additional services or making a referral to another service, with the parents, carer or pregnant woman?

- Do you have any concerns about the children's/unborn child's well-being or safety?
- Is action required to safeguard and promote the welfare of the children/unborn child?
- Do you need to discuss this or make a referral to another service?

Information to support the process of assessing risk is/should be documented in The Common Assessment Framework (CAF) Procedure http://www.warwickshire.gov.uk/caf which is "A shared assessment tool used across agencies in England". It involves identifying a lead professional where appropriate, and sharing information to avoid duplication of assessments. This also reduces the need for children or their families to re-tell their story to different practitioners. The Lead Professional (LP) is the person responsible for co-ordinating the actions identified in the assessment process and being a single point of contact for children with additional needs being supported by more than one practitioner.

## 6. Responsibility for Implementation of the Protocol

Everyone has a responsibility to take a "Think Family" approach whether they work in adults, children's or generic services. This should be monitored through first line management, case supervision, clinical supervision, live case file monitoring, closed case file monitoring and serious case reviews for adults and children. Each agency has a responsibility for putting in place and maintaining quality assurance systems to monitor compliance.

## 7. Referrals to Children's Social Care Services

When considering making a referral for a child in need or a child in need of protection to Children's Social Care Services, please refer to Section 3 of the WSCB Interagency Procedures.

When assessments are undertaken they must be holistic. When considering eligibility for services, workers must focus on the longer term needs and capabilities of the family, rather than an assessment based around the existence or absence of

incidents. Avoid the 'rule of optimism' or 'start again' syndrome, by balancing recent improvements in family circumstances against historical information regarding family functioning.

A referral for an assessment should always be made if a parent/carer or pregnant woman is considered to have significant domestic violence issues, mental health, drug and alcohol or learning disability problems as indicated by the triggers below. A referral should always be discussed with a manager. If there is immediate danger to the client/patient or others including a child the police should be contacted. Workers must ensure their decision and agreed course of action is fully and accurately documented, signed and dated and that a written referral follows any telephone conversation or referral.

If one service decides on a course of action or inaction, which cannot be agreed by another then the WSCB Escalation Policy should be followed.


Escalation Processes Booklet - Revised Nov

Examples of triggers that indicate referral to Children's Social Care Services for initial assessment are detailed below and are extracted from the Thresholds for Intervention document. This is not an exhaustive list but is provided to assist professional decision-making.

- Parent's mental ill health, learning disability or substance misuse significantly affects care of the child
- Parents unable to care for previous children
- Home environment or hygiene places a child at immediate risk of harm
- Persistent failure to take children to health appointments
- There is persistent or serious instability and violence in the home
- Parent exposes child to other adults who are not members of the family but who present a risk

- Parents unable to keep the child safe
- Chronic non-attendance at school or other educational provision attributable to lack of parental support
- Parent's habitual involvement in crime directly impacts child
- Absence of appropriate boundaries which places child at risk

## 8. Transition to Adult Services

The period of transition from Children to Adult Services can increase the risks for the needs of young people to be missed. Good practice when transitions are occurring should include:

Notifying adult services in a timely manner of young people who will be transferred to them so that adult services can plan provision.

Prepare the young person for the transition - assist them to overcome potential barriers, explain to them the new arrangements such as booking appointments and inform them of any other new expectations of them under the adult arrangements.

Ensure there is an effective transfer of good quality information about the young person.

Consider planning a 3 way meeting between the young person, the present provider and the adult service provider to facilitate introductions, share and discuss relevant information to assist the young person to take up the service.

If there is a CAF, utilise it to identify any targeted services which may be needed.

### Children and young people who may pose a risk to themselves and others

Where a young person's behaviour raises concern of risk to others it is important to ensure that Adult Services are aware through the transition process and/or safeguarding adult referral.

### Safeguarding Children to Safeguarding Adults

Where there are on-going protection issues for a young person and it is anticipated that on reaching 18 years of age the young person will be likely to meet the definition of an adult in need of safeguarding, the following should be considered as part of the transition arrangements:

- Formal handover of protection plan arrangements in a timely manner;
- Clarify who is responsible for the completion of mental capacity assessments;
- Where the young person has a current Child Protection Plan their final conference should consider any ongoing safeguarding issues.
- Where the young person does not have a current Child Protection Plan but concerns exist a safeguarding adult referral should be made in a timely manner.

## Appendix 1 - Definitions

### Definition of Child in Need

Under Section 17 [10] of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services;

  or

- He/she is a Disabled Child.

### Definition of a Child in Need of Protection

A child in need of protection will also be a child in need but assessments of their needs are undertaken under Section 47 of the 1989 Children Act which states:

Where a local authority:

a. Are informed that a child who lives, or is found, in their area

i. Is the subject of an emergency protection order; or

ii. Is in police protection; or

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

### Domestic Violence

There are a number of definitions of domestic violence which are broadly consistent with one example given below:

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'

### Home Office Website

### Safeguarding Adults

A vulnerable adult is a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. (No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, DoH and Home Office, 2000).

### Why is it called "Safeguarding Adults?"

"Vulnerable adults" became "adults in need of safeguarding" in 2005 to recognise a shift in service philosophy and practice since the launch of "No Secrets" in 2000. The term "Vulnerable Adults" can be disempowering and can also suggest that the cause of abuse is located with the victim rather than acts or omissions of others.

There can be confusion with the definition; a "Vulnerable Adult" in 'No Secrets' may be different to a "Vulnerable Adult" as defined in the Care Standards Act 2000; the definition is different yet again to that of a "Vulnerable Witness" as defined under the section 'Achieving Best Evidence' in the Youth and Criminal Justice Act 2002.

The term 'Adult Protection' implies a paternalistic approach.

'Safeguarding Adults' reinforces that all adults have the right to live free from abuse and degrading treatment, but that some people may find it difficult to afford that right. One such group of people are individuals who have community care needs.

Since the launch of 'No Secrets' (2000) it has been demonstrated that this group of people are more likely to experience abuse and may have difficulty accessing mainstream and/or specialist services to keep them safe.

## Appendix 2 - Advice and Consultation

### General Advice

Adult services and those working with children and families should feel they can seek advice and consultation prior to making referrals. This should include liaison with professionals in Primary Care e.g. GPs and Health Visitors. If it is agreed during the consultation that there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm, or an adult has a disability likely to impair parenting, then the information will need to be treated as a referral. Advice should also be sought from supervisors and team managers both within but also across service areas, i.e. children and families and adult services. Advice from more experienced colleagues in the same service can also be valuable.

### Specialist Advice

### Child Protection

The child safeguarding leads in each agency have a multi-agency responsibility to provide advice/consultation on any matter relating to child protection. However on a day to day basis advice can be obtained from the Children's Duty and Assessment team or from the allocated worker's team. The paediatrician who is the designated doctor for child protection fulfils a similar role within the health service.

### Mental Health Services/Learning Disabilities

This may be the specialist teams e.g. Learning Disabilities, Personality Disorders Service, Forensic, Drug or Alcohol, Mother and Baby, Assertive Outreach, Eating Disorders, or General Adult teams for each geographical sector. The relevant Consultant Psychiatrist can be contacted for advice on those cases raising the greatest level of concern directly through the Duty Officer or Care Manager at the relevant team base. Advice that may be used as the basis for further decision-making should be clearly recorded as part of the case file. The Safeguarding Nurse or doctor can be contacted if it is not certain which service may be or could be involved.

### Domestic Violence

Most domestic violence specialist agencies will help/support the development of a safety plan for victims. Some non-specialist agencies may also have the skills in-house to support clients to develop plans. Advice should be sought from your domestic violence lead. Formal safety risk assessment such as CAADA, DASH 2009 which are used to identify high to very high levels of risk are used by Independent Domestic Violence Advisors (IDVAs), some outreach services and agencies such as the police. Where the risk is identified as very high, cases will be referred to the MARAC process.

## Appendix 3 - Confidentiality and Information Sharing

Good information sharing is a vital part of successful multi-agency work supporting informed decision making and improvements in outcomes for families. Open and full co-operation in sharing information is essential, particularly in respect of any areas of risk for the individual or others.

All workers should seek to gain the informed consent of the adults involved before making a referral for the adults and their children or unborn children. Where information is particularly sensitive e.g. about the mental health of the adult this consent should be in writing. In situations where verbal consent is obtained this should be recorded in case notes. The adults must understand why this information is needed and who it will be shared with. Consent should not be sought from the adults in certain circumstances where sexual abuse or fabricated induced illness is suspected or if it puts the child or parent/carer in greater danger. Information can only be shared without consent where:

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

Where information is disclosed without consent it must be relevant and only disclosed to those professionals who need to know. The reasons for disclosure must be recorded and the professionals must have considered the proportionality of

disclosure against non-disclosure. The WSCB Information Sharing in Child Protection Protocol (Section 12 Appendix 6) should be applied and statutory organisations have a Caldicott Guardian who can give advice on information sharing. For further information please refer to “What to do if you are worried a child is being abused” and 'Access to Health Records', DoH, 1990.

## Appendix 4 - Decision Making, Assessments and Care Planning

Assessments should provide an understanding of the impact of family circumstances and the wider community on what is happening to a child over time. This should minimise the risk of repeated initial assessments which do not take account of cumulative concerns or continuous neglect. To ensure an effective decision making process operates in the relevant children's/adult's teams a full multi-disciplinary assessment and shared reviews are essential. It is important to consider the usefulness of joint working at all stages of the process. This may involve joint visits, shared recording, or regular telephone calls.

Assessments of the case by each team should involve any relevant professional from another team, including any specialist workers e.g. psychiatrist, psychologist, family centre worker etc.

When a referral is made between the teams there must be clarity about its purpose e.g. Mental Health Act assessment, child protection issues, joint visit to assess etc. and it must be clearly agreed who holds case responsibility in each team. Where a specialist assessment is requested from the other service, the existing care manager/social worker must retain responsibility for the case. This can be reviewed on completion of the specialist assessment.

Assessments and Risk Assessments should be recorded according to the policies and procedures of each service and shared with the other team. These will form the basis of an agreed assessment of need/risk and may necessitate a professionals meeting, child protection case conference, family support meeting, or care programme approach meeting. Each team should send a copy of their care plan to the other teams. Any changes to the care plan should also be shared.

Any information received by one team that has implications for the work or responsibilities of another should be shared, in writing. This might include Emergency Duty Team (EDT) notifications, psychiatric assessments, police reports etc.

When cases are closed, this should be done by agreement and closing summaries copied to the other services where appropriate.

Wherever possible key decisions should be made jointly.  Any unresolved difficulties should be referred to the Service Manager, Children and Families and the Adult Service Manager. The escalation process of the safeguarding boards can be invoked using the designated leads in each agency