

Contents

INTRODUCTION	PAGE 3
COMMON CHARACTERISTICS OF ABUSIVE SITUATIONS	PAGE 3
<u>Some indicators of possible Physical Abuse</u>	PAGE 4
<u>Some indicators of possible Neglect</u>	
<u>Some indicators of possible Emotional Abuse including emotional harm in situations of Honour Based Violence & Forced Marriage</u>	
<u>Some indicators of Sexual Abuse including sexual exploitation</u>	
<i>Risks associated with sexual exploitation</i>	PAGE 6
ADULT MENTAL HEALTH & CHILD WELFARE ISSUES	
<u>Introduction</u>	
<u>Implications for Parents & Children</u>	PAGE 7
<u>Collaborative Working amongst Safeguarding and Specialist Services & Adult, Wellbeing & Health</u>	PAGE 8
PARENTAL SUBSTANCE MISUSE & THE EFFECTS ON CHILDREN	PAGE 9
<u>Substance Misuse in Pregnancy</u>	PAGE 10
<u>Referral</u>	
<u>Parental Alcohol Misuse & the Effects on Children</u>	PAGE 11
<u>Alcohol Use Disorders Identification Test (AUDIT)</u>	PAGE 12
<u>Assessing whether there are Child Protection Concerns</u>	
<i>Parental Drug/Alcohol Problems & Possible Effects on Children</i>	
<u>Assessment Areas</u>	PAGE 13
<i>Child Development Needs</i>	
<i>Parenting Capacity</i>	
<i>Patterns of Parental Drug/Alcohol Use</i>	PAGE 14

<i>Family & Environmental Factors</i>	<u>PAGE 15</u>
<i>Parent’s Perceptions</i>	<u>PAGE 16</u>
<i>Child’s Perceptions</i>	
<u>Individual Responsibilities of Professionals</u>	<u>PAGE 17</u>
<u>What to do if you have any concerns</u>	
<u>Children in Need</u>	
LEARNING DISABILITY – IMPACT ON PARENTING CAPACITY	<u>PAGE 18</u>
<u>Scope</u>	
<u>Background Information</u>	
<u>Additional Screening Information for Practitioners</u>	<u>PAGE 20</u>
<u>Communicating with People with Learning Disabilities</u>	<u>PAGE 22</u>
<u>Pre-Birth Assessments</u>	<u>PAGE 24</u>
<u>Flowcharts</u>	<u>PAGE 25</u>
<i>What to do if you are concerned that a parent may have a learning disability/difficulty</i>	
<i>What happens after a referral has been made regarding a parent who may have a learning disability/difficulty</i>	<u>PAGE 26</u>

INTRODUCTION

- 9.1 Our knowledge and understanding of children's welfare – and how to respond in the best interests of a child to concerns about maltreatment (abuse and neglect) – develops over time, informed by research, experience and the critical scrutiny of practice. Sound professional practice involves making judgements supported by evidence: evidence derived from research and experience about the nature and impact of maltreatment, and when and how to intervene to improve outcomes for children; and evidence derived from a thorough assessment of a specific child's health, development and welfare, and his or her family circumstances.
- 9.2 This section summarises what is known about the impact of maltreatment on children's health and development, and sources of stress in families that may also have an impact on children's developmental progress (see also *The Developing World of the Child, 2006*). Further information on findings from the joint DfE and DoH Safeguarding Children Research Initiative and other related research can be found on the NSDU research website.

COMMON CHARACTERISTICS OF ABUSIVE SITUATIONS

- 9.3 Certain characteristics have been frequently noted in child abuse situations and whereas child abuse can occur in any situation, a high concentration of these should raise awareness regarding possible risk:
- Parental history of deprivation/abuse/rejection.
 - History of unstable and damaging adult relationship.
 - History of drug, alcohol and substance abuse.
 - History of mental illness.
 - Domestic abuse, in or out of the home, towards a child/ren or another person within the home.
 - Self harm.
 - Social isolation.
 - Previous concerns about the care of any other child/ren.
 - Scapegoating of a child as "difficult" or blaming the child.
 - Jealousy and rivalry towards the child/ren.
 - Unusual possessiveness towards a child/ren.
 - Evidence of a "special" relationship.
 - Not allowing a child/ren to interact with peers.
 - Delay in seeking treatment for child/ren.
 - Conflicting explanation or no explanations for injuries.
 - Inappropriate response to a child/ren's needs.
 - Lies and deceit in dealings with professionals, including threats and intimidation to staff.
 - Inability to gain access to a child or the family home.

Some indicators of possible Physical Abuse

- Lack of adequate or consistent explanation.
- Reluctance of child to undress in certain situations, e.g. school.
- Any bruising on a non-mobile baby.
- Bruises and scratches to face.
- Bruising to the eyes.
- Fingertip bruising.
- Linear or shaped bruises.
- Fractures to a baby.
- Torn frenulum.
- Finger or hand marks on any part of the body.
- Bite marks or pinch marks.
- Cigarette burns.
- Linear or shaped burns.
- Ligature marks.
- Burns and scalds.
- Head injury.
- Poisoning.
- Untreated injuries.
- Delay seeking professional advice for treatment.

Some indicators of possible Neglect

- Unkempt appearance.
- Poor personal hygiene.
- Poor skin condition.
- Notable change in growth/weight percentiles without adequate explanation.
- Ingestion of harmful substances.
- Dry sparse hair.
- Severe nappy rash.
- Swelling of hands and feet (red and cold).
- Emaciation.
- Low self-esteem.
- Frequent lateness/non-attendance at school.
- Destructive tendencies.
- Rocking, hair twisting, thumb sucking.
- Chronic running way.
- Compulsive stealing.
- Scavenging for food and/or clothes.
- Persistent hunger.
- Constant tiredness.
- Untreated medical problems.
- No social relationship.
- Lack of supervision.
- Withdrawn or attention seeking.

Some indicators of possible Emotional Abuse including emotional harm in situations of Honour Based Violence and Forced Marriage (see section 6)

- Physical, mental or emotional developmental delay.
- Emotional disturbance.
- Speech disorder.
- Enuresis/encopresis.
- Excessive fear of new situations.
- Excessive separation anxiety.
- Inappropriate emotional responses to stressful situations.
- Extreme anxiety about parents being contacted.
- Overreaction to mistakes.
- Rocking, hair twisting and thumb sucking.
- Compulsive stealing.
- Extremes of passivity or aggression.
- Chronic running away.
- Punishment which seems excessive.
- Self mutilation.
- Drug solvent misuse.
- Depression.
- Eating disorder.
- Suicidal tendencies.
- Low self-esteem.

Some indicators of possible Sexual Abuse including sexual exploitation

- There may be no physical signs.
- Allegation – always treat what the child says seriously.
- Soreness or bleeding or injury to genital or anal or around.
- Vaginal discharge – vaginal warts.
- Enuresis (bedwetting) – particular when previously dry.
- Encopresis (soiling).
- Sexual transmitted infections.
- Psychosomatic symptoms, e.g. persistent headaches.
- Pregnancy.
- Gender identity difficulties.
- Withdrawn and unhappy or insecure and “clingy”.
- Promiscuity.
- Affection seeking.
- Change of academic performance.
- Sleep disturbance – nightmares/insomnia.
- Sexualised behaviour.
- Inappropriate/explicit sexual knowledge/behaviour for age.
- Inappropriate masturbation.
- Exhibitionism, voyeurism.
- Running away.
- Obsessive washing.
- Fear of a particular person/place.
- Cry hysterically when nappy changed or undressed.

Version 2 – September 2011

- Poor concentration.
- Low self-esteem.
- Eating disorder.
- Attempted suicide/self mutilation.
- Alcohol, drug and solvent misuse.
- Unexplained large sums of money/gifts.
- Sexually explicit drawings.

Risks associated with sexual exploitation

- Sexualised risk taking.
- Beginning to truant.
- Occasionally going missing.
- Early signs of problem drug or alcohol use.
- Problem drug or alcohol use.
- Excessive mobile and internet use.
- Excessive mobile and internet use.
- Swapping sex for money/gifts and talking about swapping sex for money/gifts.
- Intimidation and fear.
- Contact with known perpetrators regularly going missing.

For more information see Section 6.

ADULT MENTAL HEALTH & CHILD WELFARE ISSUES

Introduction

9.4 The mental health and wellbeing of children and adults within families in which an adult carer is mentally ill are intimately linked in at least three ways:

1. Parental mental illness can adversely affect the development and in some cases the safety of children;
2. Growing up with a mentally ill parent can have a negative influence on the quality of that child's adjustment in adulthood, including their transition to parenthood;
3. Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers.

9.5 Some key factors associated with mental illness which are likely to increase the risk to a child's wellbeing are:

- the specific symptoms and characteristics of the parent's disorder, or disorders, e.g. symptoms that impinge directly on a child, such as a parent who self harms, or has delusions which threaten a child's safety and wellbeing or distort the child's experience;
- any ill effects which the mental illness, or side effects of the treatment, may have on the parent's functioning, particularly on his/her capacity to relate to and care for the child, e.g. if the parent is emotionally detached or unavailable to the child, or unable

to be reliable in providing physical care such as routines, meals or getting the child to school, then the child is more likely to be affected;

- any effects such as loss of concentration that prevent the parent ensuring the child's safety;
- both parents having mental health problems;
- any associated changes in the family structure or functioning, e.g. separation due to the parent's hospital admission, additional strain on a well parent, parental relationship difficulties due to the mental ill health of one parent.

9.6 These must be balanced against protective factors such as:

- one or more other adults in the household/family network who can meet the child's needs;
- cognitive skills or temperament of the child that enables him/her to understand and cope better than others with the adverse effects of the parent's illness;
- good socio-economic circumstances, e.g. financial security, supportive social influences.

9.7 All agencies need to be alert to signs that children and parents need help and to the signs that a child or parent may be at risk.

9.8 It is essential to understand the interactions between various factors and influences which produce negative outcomes in children and adults. There are a wide range of influences, including protective factors, which have been associated with successful adjustment in both parents and children, despite the adversities associated with parental mental illness.

Implications for Parents & Children

9.9 The fact that a parent experiences a mental illness does not automatically imply a negative impact on the parent-child relationship, nor does it suggest inevitable parental inability to parent and to adequately meet a child's needs. However, a conservative estimate is that a third of children living with a mentally ill parent will themselves develop significant psychological problems or disorders. A further third will develop less severe emotional/behavioural difficulties which may nevertheless be significant for their longer term development.

9.10 Where there are issues regarding confidentiality, matters of information sharing, confidentiality and data protection are covered in the County Durham Protocol for Working Together to Delivery Services to Adults and Children (2010).

Collaborative Working amongst Safeguarding & Specialist Services and Adult, Wellbeing & Health

- 9.11 There are some barriers in working with parents with mental health problems, which should be overcome by collaborative working. Mental illness is often stigmatised and sufferers may fear being labelled as an unfit parent and conceal the full extent of their problems. Similarly, workers may misinterpret this as concealing child maltreatment or may feel reluctant to raise issues of childcare. Abuse or neglect could be an unintentional consequence of the parent's symptoms and professionals may have insufficient knowledge and understanding of the impact of the parent's symptoms and behaviour on a child's health and development and be ill equipped to assess the risks and needs or intervene effectively.
- 9.12 Close liaison between Adult, Wellbeing & Health and Safeguarding & Specialist Services is **essential** in the interests of children and their carers. This requires sharing of information where it is necessary to safeguard the health and welfare of a child. This should also be the approach, with the consent of the family, for children and their families in order to ensure holistic and preventive interventions. See County Durham Protocol for Working Together to Delivery Services to Adults and Children (2010).
- 9.13 Additional needs of the child should also be taken into account in the context of the parent's mental illness, for example, if a child has a condition which is not attributable to the parent's illness, but impacts on the child's development and family life, such as physical illness, physical disability, sensory impairment, or developmental delay or disorder.
- 9.14 The needs of a partner should also be taken into account, e.g. the additional stress or any of his/her own health problems and needs of a carer of the child and an adult with mental health difficulties. The difficulties may be aggravated if the other parent is not able to offer positive protective factors to the child or is a perpetrator of domestic abuse or is abusive or neglectful to the child.
- 9.15 Key points in the child protection process:
- s47 enquiries should include relevant information from professionals in statutory and voluntary Adult Mental Health Services.
 - Adult Mental Health professionals should be invited to child protection conferences.
 - Care should be taken to consult all relevant Adult Mental Health professionals during each stage of the child protection process.
 - There should be explicit and ongoing links between the Child Protection Plan for the child and the care plan for the parent, e.g. in relation to hospital admissions and discharges and child placement and contact issues.
 - If a mentally ill woman is pregnant and there are concerns about the unborn baby there should be joint planning between Safeguarding & Specialist Services, Antenatal/Midwifery and Adult Mental Health Services.
 - The additional vulnerability of babies and young children should be given particular safety consideration.

PARENTAL SUBSTANCE MISUSE & THE EFFECTS ON CHILDREN

See also Chapter 9 of Working Together to Safeguard Children 2010 9.37 – 9.46.

9.16 Professionals working with substance misusing parents should recognise that children are not necessarily at risk of significant harm just because a parent uses substances. Many children of substance misusing parents receive good parenting. However professionals working with children should be alert to the possibility that substance misuse by a parent or carer may lead to a child being considered as a ‘child in need’ and may prevent a child from receiving the level or quality of care that they need.

9.17 The need is for professionals to assess the individuals parenting capacity in relation to the needs of the child taking into account the developmental stage dependency and vulnerability of the child.

9.18 All substance misuse is potentially harmful to a child. Patterns of substance misuse include:

- **Dependent use** - a compulsion to continue to use a substance in order to feel good or avoid feeling bad. When this is done to avoid apparent feeling physical discomfort it is known as *physical dependence*. When it is done to avoid anxiety or mental stress or promote stimulation or pleasure it is known as *psychological dependence*.
- **Combination use/Poly-substance use** - the use of more than one substance for example use of drugs and alcohol or the use of more than one drug.
- **Chaotic and unrestrained use** - the use or bingeing on a single drug until the supply runs out or exhaustion or heavy intoxication prevents further use.
- **Dual diagnosis** - the concurrent existence in an individual of substance misuse and one or more mental disorder. In some cases, dual diagnosis mental health problems follow on from substance misuse; for example acute psychotic disturbance or mental disorder can be an adverse effect of certain drugs. In other cases, drug use may follow on from mental health problems; for example, drug use may exacerbate or alter the cause of pre-existing mental problems.

9.19 “There is a reasonable basis in research to suggest that a child whose parent is misusing substances is at increased risk. Substance misuse can demand a significant proportion of a parent’s time, money and energy, which will unavoidably reduce resources available to the child. Substance misuse may also put the child at an increased risk of neglect and emotional, physical or sexual abuse, either by the parent or because the child becomes more vulnerable to abuse by others”.

V Lewis, 1997(Hidden Harm Advisory Council for the Misuse of Drugs 2003¹)

9.20 Many substance misusing parents have a multiplicity of problems in addition to substance misuse such as unemployment, poor accommodation, financial pressure, court appearances and social isolation. It is not the substance misuse in isolation that is an issue for families but the underlying and combined difficulties.

¹ <http://drugs.homeoffice.gov.uk/publication-search/acmd/hidden-harm?view=Binary>
LSCB Child Protection Procedures

9.21 Children's physical, emotional, social, intellectual and developmental needs can be adversely compromised by their parent's misuse of substances. These affects may be through acts of omission or commission which have an adverse impact on the child's welfare and development.

9.22 The most effective predictor of long-term adverse effects on children is the co-existence of family disharmony. There is a complex inter-relationship between domestic abuse, substance misuse, alcohol abuse and mental illness. It is the association between substance misuse and domestic abuse that gives the greatest risk of significant harm to a child.

Substance Misuse in Pregnancy

9.23 There are significant numbers of women using illicit drugs coming to the attention of midwifery services.

9.24 Substance misuse in pregnancy may lead to an increased risk of:

- Premature birth
- Low birth weight
- Newborn developing withdrawal symptoms and requiring medication or treatment.
- Death of the baby before birth or just after.
- Sudden infant death syndrome.

9.25 Some women taking substances especially opiates believe they can not get pregnant as they have irregular or absent periods. Many of these women do not seek anti natal care until late in the pregnancy or when they are in labour. This may be due to anxiety about their substance misuse or the involvement of professionals in particular Children's Services.

9.26 It is important for both mother and child that they receive appropriate advice and support as early as possible in the pregnancy, there are significant risks involved in stopping taking some substances suddenly. It is important that women seek medical advice before stopping any substances.

9.27 In cases where a newborn baby's health has been compromised by maternal drug use, for example neonatal abstinence syndrome (a child showing features of withdrawal) a referral should be made to Safeguarding & Specialist Services.

9.28 Please refer to Safeguarding the Unborn Baby (Section 5 of these procedures).

Referral

9.29 Where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the baby may be at risk of significant harm, a referral to Safeguarding & Specialist Services must be made at 20 weeks gestation unless the mother is known to abuse substances and where there are serious concerns for the unborn baby.

9.30 Where the concerns centre around a category of parenting behaviour, e.g. substance misuse, the referrer must make clear how this is likely to impact on the baby and what risks are predicted.

9.31 Delay must be avoided when making referrals in order to:

- provide sufficient time to make adequate plans for the baby's protection;
- provide sufficient time for a full and informed assessment;
- avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time;
- enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome to assessments;
- enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth.

9.32 Concerns should be shared with prospective parent(s) and consent obtained to refer to Safeguarding & Specialist Services unless this action in itself may place the welfare of the unborn child at risk, e.g. if there are concerns that the parent(s) may move to avoid contact with Safeguarding & Specialist Services.

Parental Alcohol Misuse and the Effects on Children

See also 9.47 – 9.55 Working Together to Safeguard Children 2010

9.33 Alcohol misuse is associated with a wide range of problems, including physical health problems, offending behaviours including domestic abuse, child abuse and child neglect; mental health problems; and social problems such as homelessness. The evidence indicates that much of the harm is preventable.

9.34 Around 90% of adults consume alcohol and the majority do not experience problems (MoCAM 2006).

9.35 Patterns of alcohol misuse include:

- **Hazardous Drinking** - hazardous drinkers are drinking at levels over the sensible drinking limits, either in terms of regular excessive consumption or less frequent sessions of heavy drinking. However, they have so far avoided significant alcohol related problems.
- **Harmful Drinking** - harmful drinkers are usually drinking at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers. Unlike hazardous drinkers they show clear evidence of some alcohol-related harm, many may not understand the link between their drinking and the range of problems they may be experiencing.
- **Dependent Drinking** - the main group of drinkers who clearly may benefit from specialist alcohol treatment are those who are moderately and severely dependent.

9.36 Moderately dependent drinkers may not have reached the stage of “relief drinking” (drinking to avoid withdrawal symptoms). They may recognise they have a problem reluctantly through pressure, for example from family members or employers.

9.37 Severely dependent drinkers have serious and long standing problems. Typically they have experienced significant alcohol withdrawal and may have formed the habit of drinking to stop withdrawal symptoms. They may be drinking heavily over long periods or bouts or significant daily drinking.

Alcohol Use Disorders Identification Test (AUDIT)

9.38 Simple and reliable tools can be used to identify a client's level of drinking. Alcohol Use Disorders Identification Test (AUDIT) can be used to identify hazardous and harmful drinkers and provide an indication of the likely extent and severity of their alcohol related problems.

9.39 *There is multi-agency training available throughout County Durham on the use of the AUDIT screening tool and on the delivery of advice and brief interventions for more information contact Community Alcohol Service 0191 375 6620.*

9.40 Alcohol Concern's review of the evidence base (2008) says studies suggest that problematic alcohol use by a parent significantly affects the quality of their parenting. The resulting problems for children can be grouped under three main headings anti-social behaviour, emotional problems and within the school environment learning difficulties. In addition these children have difficulties in developing trusting relationships they often suffer from a range of fears including neglect, abandonment, and fear the parent will die or leave. Effective treatment is fundamental to improving parenting capacity but it isn't enough, adult substance misuse services must see the bigger picture by viewing their client in the context of them as parents.

9.41 Good practice dictates that both Adult and Children's Services need to work collaboratively to effectively meet the needs of service users. To continue to distinguish between adult and children's workers compounds the problems for services and service users alike.

9.42 Alcohol misusing parents may be simultaneously concerned at the impact of alcohol on their children and worried they may get into trouble for being "poor parents"- even if their parenting is adequate. Those living in rural areas may benefit from domiciliary appointment or help with transport.

9.43 Pregnant women and those trying to become pregnant should be informed of the current advice on alcohol and its effects on conception and during pregnancy. Women who are dependent on alcohol and are pregnant or currently trying to become pregnant should be referred immediately for specialist alcohol treatment.

Assessing whether there are Child Protection Concerns

Parental Drug/Alcohol Problem and Possible Effects on Children

9.44 Substance use/misuse by parents/carers does not on its own automatically indicate that children are at risk of abuse or neglect, although it is essential that workers recognise that these children are considered a vulnerable group and that the situation needs careful assessment.

9.45 The following information is to help assess the possible impact on the child of parental substance misuse.

Assessment Areas

Child development needs

9.46 This section relates to how the child is progressing in terms of their overall development.

9.47 An assessment needs to take account of the provision of basic needs for child who are dependent on their parent/carer for their care (e.g. babies and younger children), problems which could result in children being emotionally isolated, children who are missing from school or struggling at school, and children who are having difficult relationships with parents/carers or peers. The following needs to be considered:

- Does the child experience many accidental injuries? This could indicate poor supervision.
- Is the child exhibiting any signs of anxiety about their situation or poor self-image/low self esteem; few friends, withdrawn, poor concentration, poor quality relationships, attention seeking behaviour, overtly clingy with parents/carers, or is the child overly familiar with a worker.
- Is the child attending nursery/school regularly and on time? Are they up to date with health and dental checks?
- For older children/young people, what is their understanding and experience of the drug taking or alcohol misuse?
- Does the child/young person have anyone to talk to?
- How does the parent explain their substance misuse to the child?
- Are there any indicators that the child is taking on a parenting role within the family; caring for parents/carers or other children, excessive household responsibilities?

Parenting Capacity

9.48 The section concerns the pattern of parental drug/alcohol misuse and the extent to which this affects their capacity to effectively meet the child's needs. Risks to children are greater where a partner also has drug/alcohol problems. Higher risks are associated with:

- Drug/alcohol use that results in periods of severe intoxication and withdrawal.
- Chaotic drug/alcohol misuse may lead to dramatic changes in parental behaviour.
- Drugs/alcohol equipment left around the house.
- Social contact includes others with drug/alcohol problems, e.g. dealer's.

- Where children witness drug/alcohol use and other inappropriate or frightening behaviour, e.g. domestic abuse.

Patterns of Parental Drug/Alcohol Use

9.49 The following needs to be considered:

- Is there a parent or supportive partner without a drug/alcohol problem?
- Are they aware of the drug/alcohol problems and are able to talk about them?
- How involved are they in the child care?
- What drugs/alcohol is being used?
- Are there multiple drugs or drug and alcohol misuse combinations?
- What are the physical and emotional effects on the parents?
- What changes can the parents make to their substance misuse to reduce the concerns? e.g. reduction in consumption, change from injecting to oral use, reduction in frequency, or move from buying drugs to substitute prescribing.
- Has the pattern of drug/alcohol use increased or decreased in stability over the last few months?
- Do the parents recognise the affect the drug/alcohol has on their children and their parenting?
- What changes does the parent want to make to their drug/alcohol misuse? Are they realistic? Is the parent motivated to make these changes?

Effects of Drug/Alcohol Use on Capacity to Meet Needs

9.50 The following needs to be considered:

- Does the drug/alcohol use compromise the ability of parents to meet their children's needs for food clothing, and warmth?
- Are bills paid and food bought appropriately?
- Does the parent accompany the child to nursery/school?
- Does that parent ensure the child is safe on their journey to school/nursery?
- Who looks after the children whilst the parent/carer obtain drugs/alcohol or funding for the drugs/alcohol?
- If care is planned ahead is the carer suitable? (i.e. appropriate age and maturity, not a chaotic user)

- What arrangements are made for the child's safety during the drug/alcohol use?
- Are the parents aware of the dangers of their children accessing their drugs/prescribed medication/using paraphernalia?
- Do they use a safe storage system?
- Does the drug/alcohol use affect the parent's ability to offer emotional warmth, e.g. does it result in insensitive, unresponsive or critical interactions with the child?
- Does the drug/alcohol use compromise the parent's ability to offer stimulation, e.g. does the parent regularly play/ read to the child?
- Does the child witness drug use, drunken criminal behaviour either by parents or others?
- Is life for the child unpredictable? Is it dependent on how successful the parent has been at acquiring their drugs/alcohol and keeping out of trouble?
- Are levels of child care different when a parent is using drugs/alcohol?

Family and Environmental Factors

9.51 This section places the family within the wider family and socio economic context. Particular risk factors include contact with social networks consisting of alcohol/drug users and dealers, employment and isolation from extended family/community.

9.52 The following needs to be considered:

- Are relatives aware of the alcohol/drug problems?
- Do relatives use drugs/alcohol themselves?
- Are they supportive practically or emotionally?
- Are they involved in child care and how much?
- Does the family remain in one area or move frequently?
- If the family move frequently what affect is this having on the children, e.g. has it disrupted their relationships, education, health care arrangements?
- Is the home appropriate for the children?
- Is it used for dealing or for drug/alcohol use by others?
- Is the family socially isolated?
- How much is the drug/alcohol use costing?
- Is the family income being diverted to pay for drugs/alcohol?

- What problems is this causing?

Parents Perceptions

9.53 Parents who show awareness and insight into their problems are more likely to attempt change. Workers should emphasise the importance of stability and any decisions about treatment e.g. detoxification should be considered in terms of their potential impact on immediate parenting and childcare.

9.54 The following needs to be considered:

- Is the parent able to identify any factors that underpin or trigger their drug/alcohol use?
- How does the parent explain the drug/alcohol use to their children/family?
- What do they think needs to happen to enable them to make changes to their life style? Is this realistic?
- What if any concerns do they have about the affect their use may have on their relationship with their child/family?

Child's Perception

9.55 The ability to gather information from children will be dependent on their age and stage of development: however, this is a vital aspect of the assessment process. It is good practice that the child is spoken to on their own.

9.56 The following needs to be considered:

- What does the child know and understand about the parent's drug/alcohol use?
- How their daily life is affected, both when the parent is under the influence of drug/alcohol and when they are not?
- Do they have fears, anxieties or hopes about their parent's behaviour?
- Are the drugs and alcohol accessible to the child?
- What if any change would the child/young person like to see?
- What if any support does the child/young person want and from whom?

Individual Responsibilities of Professionals

- 9.57 Many professionals are likely to come across substance misuse in families and it is important that any areas of risk are recognised at an early stage so that intervention and services can be offered to support the family and ensure that the children of the family and improve the life chances of the children within the family.
- 9.58 Professionals need to be open and honest with the parents and carers they work with but remain focussed on the needs of the child where their safety may be compromised.
- 9.59 The safety and welfare of children in families is everyone's responsibility.

What to do if you have any concerns

- 9.60 Seek advice from your line manager; speak to other workers involved with the family to get a fuller picture.
- 9.61 If you feel that the child has additional or unmet needs, a pre-CAF should be completed.
- 9.62 If any needs are identified then you should complete a full Common Assessment Framework with the family and if appropriate arrange a Team Around the Child (TAC) multi-agency meeting within 10 days.

Children in Need

- 9.63 Children who are defined as being 'in need' under Section 17 of the Children Act 1989, are 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 service(s). A child with a disability is a child in need.
- 9.64 In cases of parental/carer misuse of substances early intervention is recommended to prevent neglect of the children. This intervention can be provided under the Children in Need Procedures. For example, substance misuse is prioritised over buying food, heat, light or attention to the child.
- 9.65 Any one of these factors is initial indicators of a pattern of neglect developing. Local research in Durham suggests that neglect is prevalent in cases featuring substance misuse.

9.66 Working Together to Safeguard Children (s1.32-1.36) sets out definitions of the four broad categories of abuse which are used for the purposes of making a child subject of a Child Protection Plan. Below is the definition for Neglect.

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision including the use of inadequate care-givers, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

9.67 The key action required is a full assessment, with the primary focus on the needs of the child rather than the parent's drug use per se, this assessment should be based on the Framework for Assessment of Children in Need and their Families (DoH 2000).

9.68 If you identify a child is at risk of significant harm follow Section 5 of these procedures.

LEARNING DISABILITY - IMPACT ON PARENTING CAPACITY

Scope

9.69 These procedures should be applied to parents with a learning disability, i.e. IQ under 70, however, many principles contained in these procedures should be applied to parents with learning difficulties.

Background Information

9.70 **Having a learning disability is not an indicator of parenting ability.** What it may indicate is the need for an assessment of their parenting capacity.

9.71 It is important to identify at an early stage the parent's ability to understand any safeguarding concerns being expressed by professionals.

9.72 Good practice guidance on working with parents with a Learning Disability has been identified in a legal case RP and Nottingham City Council and Official Solicitor March 4th 2008 England and Wales Court of Appeal (Civil Division) Decisions

9.73 This case outlines the care that needs to be taken in assessing a parent's ability to understand a child protection plan and any legal proceedings undertaken.

9.74 This is a lengthy case but there is specific guidance for Local Authorities contained in Paragraphs 169-182.

9.75 If a social worker believes that legal proceeding will be instigated at the time or in the future it is essential that legal advice is sought at the earliest opportunity from the Local Authority solicitor.

9.76 Learning disabled parents may need additional support to develop their understanding, resources, skills, and experience to help them meet the needs of their children.

9.77 This will certainly be much more likely where other stress factors are present such as:

- Domestic abuse
- Poor Physical health
- Poor mental health
- Substance misuse
- Poor housing Social isolation
- Poverty
- A history of growing up in care

9.78 Children of learning disabled parents are at increased risk from:

- Inherited learning disability
- Psychiatric disorders
- Behavioural problems.
- Poor educational achievement

9.79 The presence of such factors will add additional pressures for parents. It does not necessarily follow however that such factors **will** occur only that the prevalence is significantly higher.

9.80 Children may take extra responsibility for caring for themselves and at times their siblings, parents and other family members.

9.81 A mother with a learning disability may be at increased risk of being targeted by men who would wish to gain access to children for the purpose of abusing them.

9.82 A mother with a learning disability may have difficulty in protecting children from all forms of abuse, particularly if there is in violence and aggression in the adult relationship.

9.83 Where concerns exist about a child's welfare or a parent's ability to meet their child's needs, an assessment must be undertaken using Framework for the Assessment of Children in Need and Their Families.

9.84 It is important to establish as soon as possible the level and extent of any learning disability or learning difficulty.

9.85 To meet the threshold of having a learning disability, adults must meet three core criteria:

1. Significant impairment of intellectual functioning: i.e. individuals with an IQ of 69 and below (Reference British Psychological Society & World Health Organisation. IQ and the associated global ability index scoring system should only be assessed by a chartered psychologist trained in using the appropriate accredited assessment tools.
2. Significant impairment of adaptive/social functioning, for example, needing help with self care, communication, reading, writing, managing finances, access to the community.
3. Age of onset before adulthood: in order for the individual to be considered as “learning disabled”, impairment, i.e. of intellectual adaptive/social functioning needs to have been present before the age of 18 years.

Additional screening information for practitioners

9.86 **These initial questions may assist practitioners in the identification of a learning disability.** These questions do not diagnose a Learning Disability but may assist professionals to identify when there may be a need to speak to a member of the Community Learning Disability Team to decide whether further assessment is indicated to assess possible Learning Disability.

1. **Did they attend special school or need extra help at school if in mainstream school? Did they achieve any educational qualifications? (see info below)***

Durham County Council's internet site has a link with information of all schools in County Durham. This link contains a guide to special educational needs provision in County Durham.

Attending one of these schools does not necessarily mean that the person is appropriate to refer to the adult learning disability services. However if the person attended any of the schools listed under the following sections it may be worth considering a referral to the adult learning disability team for assessment & possible service intervention.

"Special Schools" (provide education to the most learning disabled children in the County).

"Learning Difficulties" (Mainstream schools provide education to pupils who are generally less intellectually impaired than the children in the first section).

"Special schools for children with social, emotional & behavioural difficulties" (it may be worth considering a referral to the adult learning disability service for parents who attended these schools These young people may or may not have a learning difficulty).

Note

If a young person has attended any of the schools listed above this probably means that they have a special need which is a need other than a learning disability or learning difficulty. They may for example need a referral to the sensory impairment team rather than a learning disability team.

If you are in doubt about an appropriate referral you should ask the adult learning disability service to carry out a screening assessment as to whether the person meets the criteria for the learning disabilities as opposed to learning difficulties.

2. **Have they received support from learning disability services in the past (as either a child or adult)? This needs to be confirmed by contacting the Community Learning Disabilities Team**
3. **What did they do after leaving school? Did they go to College/attend a day centre/go to work?**
4. **Are they in receipt of any benefits, e.g., DLA? (this may indicate evidence of disability)**
5. **Do they require support from family members or professionals from Learning Disability services in order to manage everyday tasks? (e.g. Psychiatry, Psychology, Nurses, Social Workers)**
6. **Are there any significant & severe problems with reading and writing? Can the person, for example read & write at all. Can they read correspondence?**
7. **Do they seem to understand requests or comments and follow them through? Have you seen evidence to indicate a response either way?**
8. **Does the person have epilepsy?**

9.87 More information can be found on the [Mencap](#) website in the section on Learning Disability.

9.88 Using the screening questions should assist practitioners to identify early in the assessment if a full assessment by a psychologist is required.

9.89 Answering yes to one or more of the questions above may indicate a learning disability.

9.90 If early indicators suggest a full assessment for possible learning disability may be needed, a discussion with the **Learning Disability Intake Team** should take place as soon as possible. **Telephone number 01388 424201**

Note for Readers

9.91 Not all parents who present as having learning disabilities meet the criteria identified above but some may have a learning difficulty as opposed to a disability. Many parents who have a learning difficulty are able to provide good parenting.

- 9.92 Learning difficulties is a widely used phrase but unlike learning disability does not have a firm parameter around diagnosis or definition.
- 9.93 Learning difficulties for example sometimes gets used by a range of agencies in relation to people who may, in fact, be in the mainstream intellectual range but are in the lowest section of the mainstream range.
- 9.94 It is important that any assessment where children are involved is based on parenting capacity. Parents with a learning disability or a learning difficulty should not be assumed to have potential problems with parenting or indeed not to have capacity for improvement.
- 9.95 Any assessment needs to consider the extent and vulnerability of the child/children, what other support or services are available, and be grounded in evidence based knowledge.
- 9.96 Many people with learning disabilities/difficulties have poor experiences of services and may be reluctant to admit difficulties. They may present with fluent speech, incorporating jargon and technical terms in their phrases. Some phrases have been learnt as a whole with little understanding of their true meaning. See communication information below.

Communicating with People with Learning Disabilities

“Sometimes I've got the words in my mind, and I'm trying to explain it in the best possible way, but it doesn't always come out.”

9.97 Try to imagine:

- not being able to read this
- not being able to tell someone else about it
- not being able to find the words you wanted to say
- opening your mouth and no sound coming out
- words coming out jumbled up
- not getting the sounds right
- words getting stuck, someone jumping in, saying words for you
- people assuming what you want, without checking with you
- not hearing the questions
- not being able to see, or not being able to understand, the signs and symbols around you
- not understanding the words, phrases or expressions
- not being able to write down your ideas
- being unable to join a conversation
- people ignoring what you are trying to say, feeling embarrassed, and moving away
- people not waiting long enough for you to respond in some way, assuming you have nothing to say, and moving away.

“ It makes me feel as if I'm not worthy of being able to communicate. I can communicate, but in a different way to other people, and it makes me feel quite upset when people don't understand.”

9.98 Whatever way you are trying to communicate with someone with a learning disability, there are some simple rules you can follow for good communication. It is important to always use accessible language, and to avoid jargon or long words that might be hard to understand. You should also take into account any physical disabilities the person may have that could make communication difficult for them.

Tips for Communicating

1. Find a good place to communicate in - somewhere quiet without distractions. If you are talking to a large group be aware that some people may find this difficult.
2. Ask open questions - questions that don't have a simple yes or no answer.
3. Check with the person that you understand what they are saying - "the TV isn't working? Is that right?"
4. If the person wants to take you to show you something, go with them.
5. Watch the person - they may tell you things by their body language and facial expressions.
6. Learn from experience - you will need to be more observant and don't feel awkward about asking grandparents or carers for their help.
7. Try drawing - even if your drawing is not great it might still be helpful.
8. Take your time, don't rush your communication.

“I'm quite good on the phone as long as people tell me what they want and speak clearly and slowly. Then I can understand.”

9. Use gestures and facial expressions. If you are asking if someone is unhappy make your facial expression unhappy to reinforce what you are saying.
10. Be aware that some people find it easier to use real objects to communicate but photos and pictures can really help too.

To be a successful communicator with people with a learning disability you need to be prepared to use all your communication tools.

You need to follow the lead of the person you are communicating with.

You need to go at their pace, to check you have understood and be prepared to be creative
(Reference: Mencap)

Pre-Birth Assessments.

- 9.99 In the LSCB procedures in Section 5 there is information on carrying out pre-birth initial assessments entitled "[Safeguarding the Unborn Child](#)".

Notes

- 9.100 Some women with a learning disability may not recognise they are pregnant until late in their pregnancy.
- 9.101 An early assessment should identify what support is available for the parents and what areas of concern the professionals have if any. This should be based on the needs of the child.
- 9.102 Early recognition and communication between appropriate agencies is essential to safeguard and promote the welfare of the unborn child.
- 9.103 A pre CAF (Common Assessment Framework) should identify any unmet need and professionals should then, working with the parents complete the full CAF.
- 9.104 If any safeguarding concerns are identified then the professional should follow the LSCB Procedures.
- 9.105 As children's needs change parallel to their development, parenting needs to match these changes.
- 9.106 Some parents with a disability are very successful at parenting babies and young children but have problems with more demanding adolescent children.
- 9.107 Assessments need to constantly monitor the current child's needs against the parent's ability to meet the needs.

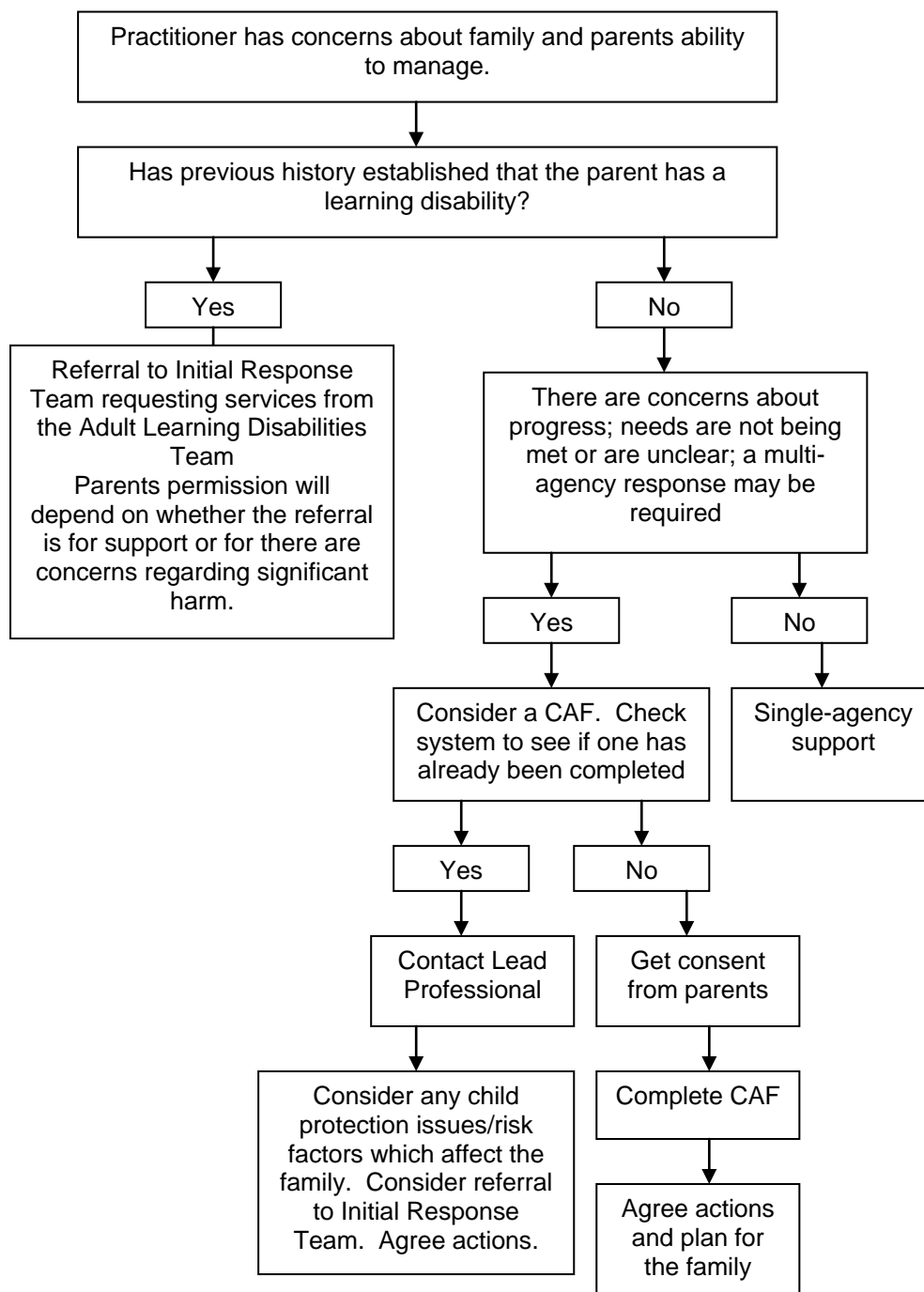
Note

- 9.108 There is a considerable body of research in the UK & other countries around the parenting capacity of people with learning disabilities/learning difficulties.
- 9.109 Practitioners are directed in particular to the work of Professor Tim Booth who is the main writer in the UK on this issue.
- 9.110 Professor Booth has written extensively on this issue. He is based in the Social Policy department of Sheffield University.
- 9.111 "Parenting Under Pressure" (Open University Press, 1994), "Growing Up with Parents who have Learning Difficulties" (Routledge, 1998) and "Advocacy Support for Parents with Learning Difficulties" (Pavilion, 1998).

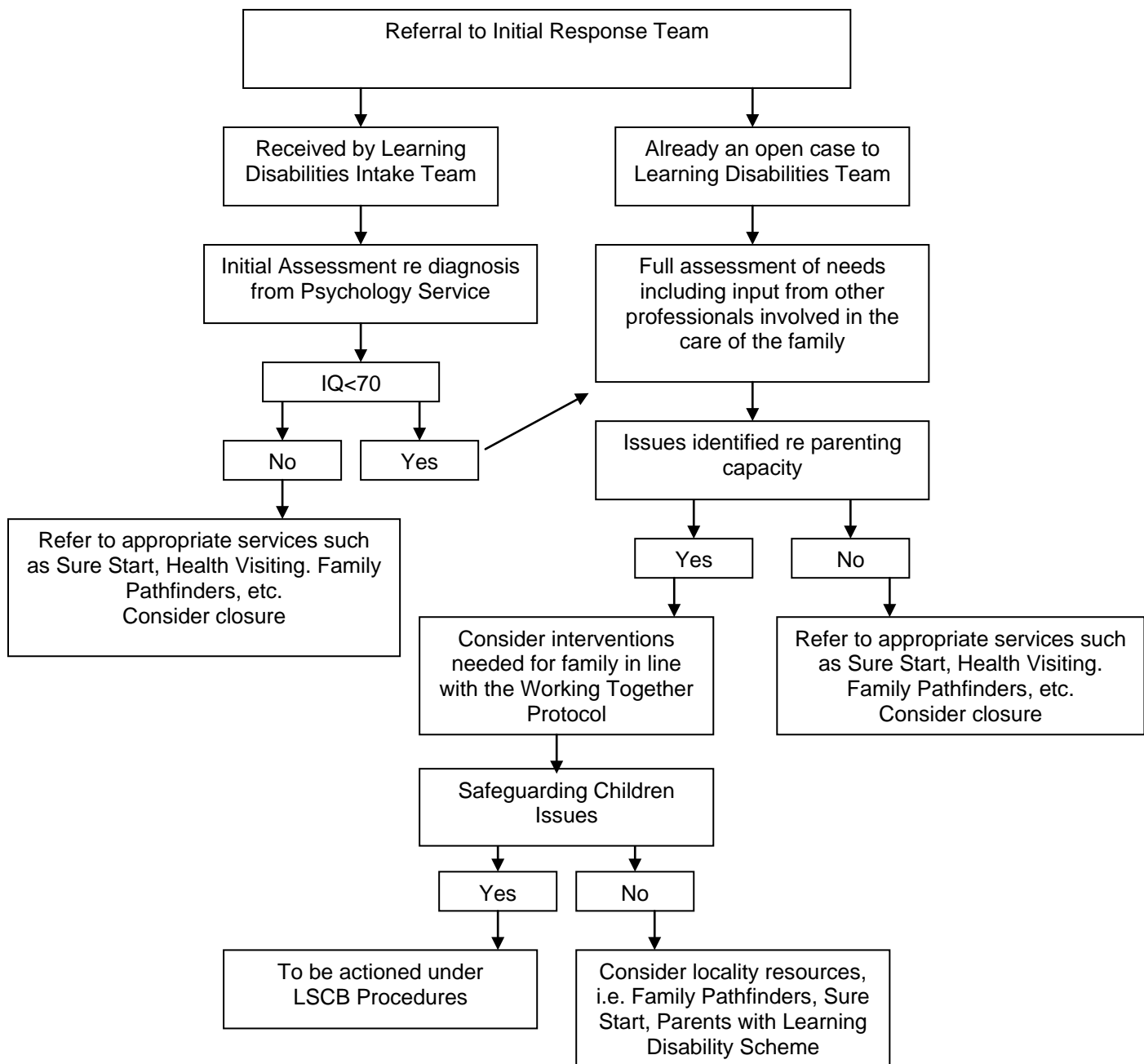
Flowcharts

The following flowcharts are aimed to assist practitioners through the assessment process.

What to do if you are concerned that a Parent may have a Learning Disability/Difficulty



What happens after a referral has been made regarding a Parent who may have a Learning Disability/Difficulty



If at any point in the process a professional is concerned about a parent’s ability to care for their child and there are safeguarding concerns, Section 5 of these procedures should be followed

If a social worker believes that legal proceeding will be instigated at the time or in the future it is essential that legal advice is sought at the earliest opportunity from the Local Authority solicitor.