



Practice Guidance for Professionals when Working with Parents with Mental Health Problems

CONTENTS

1. Introduction
2. Aims and Scope of the Practice Guidance
3. Relevant Legislation
4. MAPPA
5. Roles and Responsibilities
6. Information Sharing
7. Framework for Joint Working
 - a) Principles
 - b) Process and Procedures
 - i. Identification
 - ii. Consultation
 - iii. Referral
 - iv. Emergency Situations
 - v. Assessment
 - vi. Case work, planning and review

1. Introduction

- 1.1. Many adults suffering from mental health problems fulfil their role as parents with considerable love and care and the fact of their mental illness alone should not be seen as a basis to scapegoat or stigmatise them.
- 1.2. The mental health problems of parents, however, are associated with a range of poor outcomes for their children. These may include low self esteem, educational underachievement, poor quality relationships and emotional and behavioural problems. In a small minority of cases it is associated with the physical sexual and emotional neglect and abuse of children and in rare cases, their deaths.
- 1.3. It is essential therefore that whenever any professional is working with families where a parent has mental health problems the child or children's needs are recognised as of paramount importance and are always considered in any assessment or ongoing casework.

2. Aims and Scope

- 2.1. The aim of this guidance is to ensure that for families where a parent is suffering from a mental health problems they benefit from an integrated process of assessment and service delivery that best promotes the safety and welfare of children while respecting the rights of the parents.
- 2.2. In order to achieve this it seeks to promote understanding of the respective agencies' legislative framework, their roles and responsibilities and to provide a framework for joint assessments and service.
- 2.3. While primarily aimed at adult mental health and children's social services professionals, it will also have relevance for any agency working with families where there are mental health problems, especially for health visiting and midwifery services where risks to unborn children and the incidence of post natal depression will be being addressed.
- 2.4. This document sits underneath the KSCB Safeguarding Procedures guidance in relation to the mental health of parent or carer [KSCB Safeguarding Procedures](#) and should be read in conjunction with it.

3. Relevant Legislation

Adult Mental Health

- 3.1. The work of the Community Mental Health teams is underpinned by the NHS and Community Care Act 1990 and the Mental Health Act. Both require a systematic, objective and anti discriminatory assessment of need for clients referred to the team and a process for addressing those needs. The Care Programme Approach (CPA) is used as the framework for the delivery of all care within the mental health services. This determines eligibility and the standards of service delivery that can be expected.
- 3.2. The Mental Health Act allows for an assessment of a person's mental state to determine whether a hospital admission under detention is required. The assessments are normally completed by two Doctors, ideally a Consultant Psychiatrist and the person's GP, and a further assessment by an Approved Social Worker (ASW) to be renamed Approved Mental Health Professional

(AMHP) from October 2008. An assessment of risk is a fundamental part of this process and may be about risk to others as well as to the individual. A summary of the key sections of the Act is attached at Appendix 1.

- 3.3. The Code of Practice recommends that the least restrictive option is taken when considering the outcome. Therefore, the majority of people with mental illness are supported and treated in their own homes.

Children's Social Services

- 3.4 The work of Children's Social Services teams is primarily directed by the Children Act 1989. Under Part III of the Children Act it is the duty of every local authority (in addition to the other duties imposed on them by this part) –

- a) *to safeguard and promote the welfare of children within their area who are in need; and*
- b) *so far as is consistent with that duty, to promote the upbringing of such children*

by their families, by providing a range and level of services appropriate to these children's needs.

Section 17 (10) says: '*...a child shall be taken to be in need if –*

- a) *he is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health and development without the provision of services by a Local Authority;*
- b) *his health or development is likely to be significantly impaired, or further impaired without the provision for him of such services; or*
- c) *he is disabled*'.

A child is defined by the Children Act 1989 as a child until she/he reaches their 18th birthday

Section 47(1) of the Children Act 1989 states that:

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*
 - iii. *has contravened a ban imposed by a curfew notice imposed within the meaning of Chapter 1 of Part 1 of the Crime and Disorder Act 1998; 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 will 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.*

- 3.5 In addition, if children or young people are providing care to a member of their family or household then, as a young carer, they are entitled to an assessment of need under Section 17 of the Children Act 1989.

- 3.6 In all cases Children's Social Services will work to assess and provide services that, wherever possible, will ensure children are able to remain in the care of their parent or family.

4. Police

- 4.1. A small proportion of parents with mental health problems may become known to the police and may be subject to the Multi Agency Public Protection Arrangements (MAPPA). Effective interagency cooperation is key to these arrangements including sharing information and applying specialist knowledge e.g. from social care agencies in relation to mental health or child protection issues.
- 4.2. Information regarding MAPPA can be found at Section 13 of the [KSCB Safeguarding Procedures](#)

5. Roles and Responsibilities

Community Mental Health Teams

- 5.1. Community Mental Health teams are always multidisciplinary typically with medical, nursing, social work, psychology and occupational therapy staff. Their remit is to work with people with serious mental illness providing skilled assessment, treatment and support in the community. All mental health teams have a clear responsibility for identifying areas of risk in relation to children in need during their assessment and on-going work with adults. They will also identify and provide assessments of adult Carers and identify and refer to the local children's service any young Carers in the family. See 3.5 above.

Children's Social Services Teams

- 5.2. Children's Social Services teams are comprised of Team Leader, Practice Supervisor(s), Senior Practitioners, Social Workers and Social Work Assistants.
- 5.3. Their primary responsibility is to ensure that children are kept safe from risk and harm and that their wellbeing is promoted, within their own families wherever possible.
- 5.4. Kent Children's Social Services operate a clear eligibility criteria (attached at Appendix 2).
- 5.5. Social Workers will undertake assessments in accordance with the framework for the assessment of children in need and their families. They also undertake child protection enquiries and investigations either as a single agency or with the police. They are required to respond immediately in a situation where a child is in immediate danger or in need of protection.
- 5.6. In other situations they are required to initially assess a child and their family within 7 days and complete a Core Assessment when required within 42 days. Clear timescales are also laid down for all subsequent work including Child in Need, Child Protection and Looked After Children reviews.

- 5.7. In all this work Social Workers are required to seek and incorporate advice and information from other agencies and work closely with them to promote the welfare of the child.

5. Information Sharing

- 5.1. Module 3 of the KSCB Safeguarding Procedures provides clear and comprehensive guidance on relation to the sharing of information between professionals [KSCB Safeguarding Procedures](#)
- 5.2. If there are concerns about a child's development or welfare, professionals working with the family must cooperate to enable the proper assessment of the child's circumstances, provide any support needed and take action to reduce the risk to a child. This will normally require them to share relevant information and, in a situation where a child is at risk of harm, it is imperative that they do so.
- 5.3. Parents should always be advised of the circumstances in which information about them and their children will be shared and their consent always be sought, unless it would place the child or others at greater risk of harm to do so.
- 5.4. If parents refuse to give consent to a referral and it is felt that the risks to the child override this then this, too, should be explained to the parent. The fact that a parent has a mental health problem should not, of itself, preclude the seeking of consent and the provision of information.
- 5.5. By law the welfare of the child is paramount. This means that children's needs will override those of the adults and that the welfare principle enshrined in the Children Act 1989 takes precedence over the Mental Health Act 1983 in all situations.

6. Framework for Joint Working

Underpinning Principles

- 6.1. In all situations where there are concerns that a parent's mental health problem is impacting or may impact on the health and wellbeing of their child or children then the following principles will apply:
- The needs of the child are paramount and must be considered in every assessment and regularly reviewed. This includes the needs of unborn children.
 - Any assessment of the child and his/her situation should include talking to the child – alone if he/she is of sufficient age and understanding, and observing the child with his/her parent(s).
 - The presence of another parent or carer should not automatically be assumed to be a protective factor as they may also be suffering from the stress or impact of their partners mental health problems which may adversely affect their ability to protect.
 - Parents with mental health problems should be accorded the same respect and consideration as all other service users. Wherever possible their views, wishes and feelings should be elicited and recorded and their comment sought for any action taken. Circumstances in which their consent is overridden should be explained and the explanation put in writing to them.

- Professionals in key agencies should make every effort to understand each others legislative frameworks, roles and responsibilities and this should be underpinned by joint training which is mandatory for every professional member of staff.
- Both Children's Social Services and Adult Mental Health agencies have a duty to provide such training and all workers have a responsibility to attend the training which is provided for their professional development. KSCB endorses this and provides relevant training in addition.
- Children's Social Services Duty and Initial Assessment teams and the Community Mental Health teams should each appoint a link worker within each of their teams to take a lead in consultation and liaison with each others service to develop and build knowledge, expertise and joint working processes. This is not a substitute for all professionals developing appropriate knowledge but an addition to it.

Processes and Procedures

- 6.2. In any situation where a parents mental health problem is impacting or may impact on their child or children, including unborn children, a range of processes are available to professionals and should be considered.

i. Identification

As soon as any professional identifies a situation where a child or children are living with a parent with mental health problems they should be alert to the possibility of a range of concerns for the child. These may include:

- A child acting as a young carer for a parent or a sibling
- Child having restricted social and recreational activities
- Child's physical and emotional needs neglected (may be associated with parental depression)
- Impact has been observed on child's growth, development, behaviour and/or mental/physical health, including alcohol/substance misuse and self-harming behaviour
- The parent/carer's needs or problems taking precedence over the child's needs
- Insufficient alternative care for the child within extended family to prevent harm
- Misuse of drugs, alcohol or medication
- Delusional thinking directed towards the child
- Previous referrals on the children to Children's Social Services

In the event of an unborn child, the ability of the parent to obtain antenatal care and to provide good enough care for herself and the baby after birth must be considered.

In all these cases the professional must discuss the situation with their supervisor focusing on the needs of the child, identifying any possible concerns and protective factors and, within that forum, making clear decisions about any

further action required. A completion of a CAF may assist in these circumstances.

A minimum requirement would be for that professional and her supervisor to review the situation regularly and maintain a focus on the child's needs. The discussion and the subsequent reviews should be recorded by the supervisor.

ii. Consultation

Where concerns for the child arise, then, if the situation is not an emergency and the way forward is unclear, then professionals should consult initially with their designated Child Protection lead and subsequently, if agreed, with the Children's Social Services team. Children's Social Services may also require consultation from the Community Mental Health team regarding possible indications of parent's mental health problems and processes should be in place to facilitate this.

Consultation may result in no further action being taken, the current action being endorsed, signposting to another agency for help and advice, or a request for a referral to be made.

All consultations should be recorded and shared with the consultee.

iii. Referral

a) In relation to children

Where Children's Social Services eligibility criteria is met, in cases of referral to Children's Social Services, all referrals of Children in Need should be made using the multi agency referral form. A CAF, if it exists, should be attached. Referrers should receive a written acknowledgement of receipt and discussions should be held with them, by Children's Social Services, in relation to planning the assessments to be undertaken. All referrers should receive written feedback concerning the action taken by Children's Social Services in relation to their referral.

b) In relation to parents with a mental health problem

In the event of Children's Social Services or another agency becoming concerned about the mental health of a parent then they should initially discuss the situation with the family's GP and following this, if agreed, complete a written referral requesting a psychiatric assessment of the parent, with specific reference to their ability to safely parent their children.

All such assessments should be completed swiftly and information provided in writing to the referrer.

iv. Emergency Referral

In the event of an emergency where a child is felt to be at immediate risk, a Child Protection Referral should be made verbally or by fax to the County Duty Service who will contact the relevant Children Social Services Duty Team immediately to respond. Children's Social Services will always consult with the referrer in those circumstances, often as part of a strategy discussion that will involve the police and may involve other professionals. A joint agreed approach, including joint visits if appropriate is essential in these circumstances.

In the event of Children's Social Services having urgent or significant concerns about a child in relation to parental mental health problems then they will immediately refer to the local Community Mental Health team for an urgent mental health assessment. Again a joint agreed approach by both agencies including joint visits if appropriate, is essential in these circumstances.

If Children's Social Services or the Mental Health services feel that there is a lack of cooperation from the other agency, this should be resolved by the respective agencies' senior managers. In all cases the welfare of the child must be the paramount consideration.

v. Assessment

All requests for assessment from any agency should be acknowledged in writing and all referrers should be consulted about what information they hold and to jointly plan any response. Joint visits should be undertaken wherever possible.

In the event of a specialist assessment in relation to a parent's mental health being requested, that assessment should always make reference to what risks, if any, are posed to the child by the parent. This is particularly important if mental health professionals are assessing actual or suspected abusers who are parents or carers of children.

vi. Case Working/Planning/Review

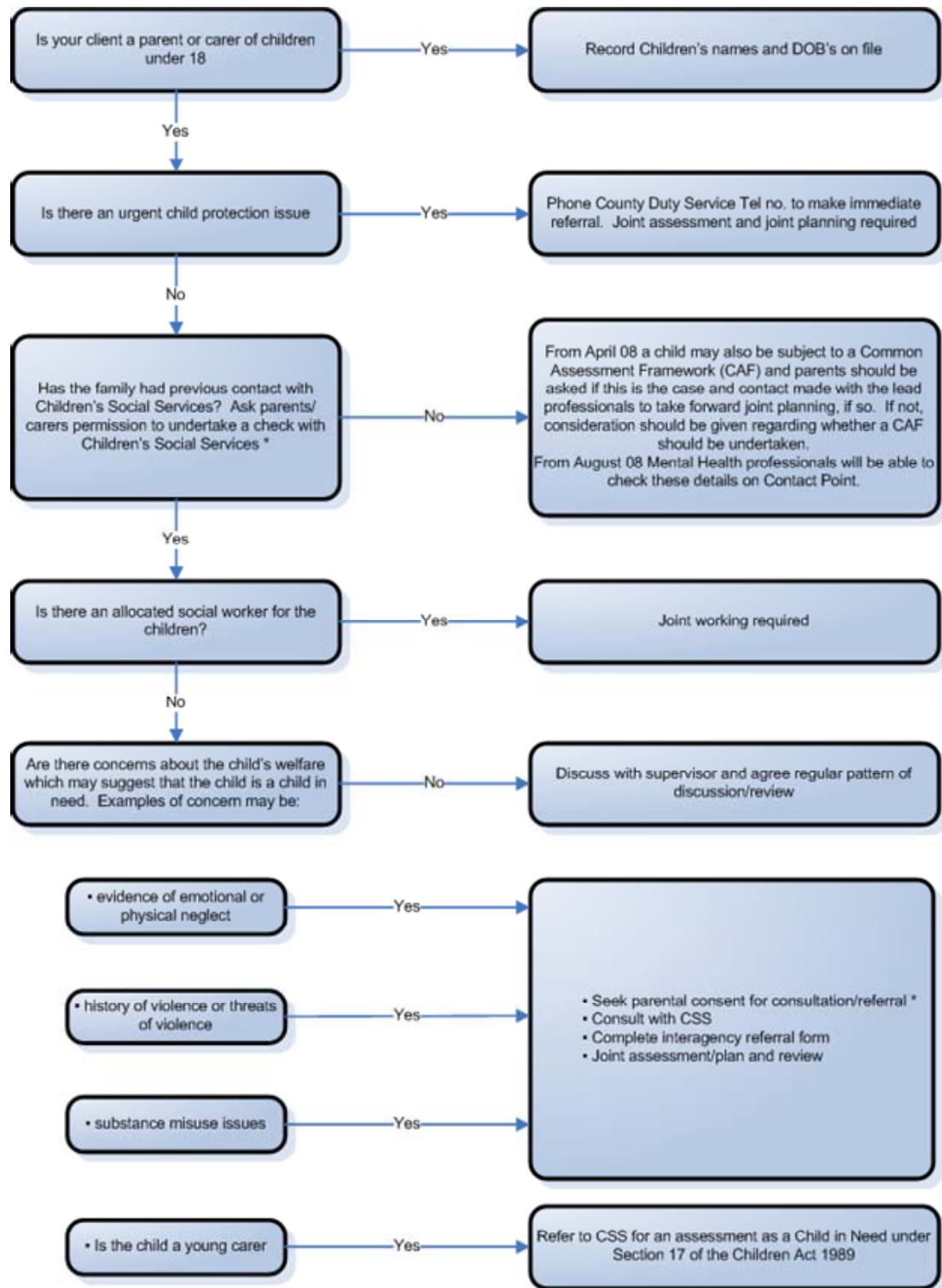
Good multi agency assessments provide the essential foundation for ongoing work, planning and review.

Where a situation involves longer term work then ongoing joint working is essential and key decisions should be discussed and made in a multi agency context.

It is essential that mental health professionals are invited and do attend child case planning meetings including Children in Need meetings, Child Protection Case Conferences and, where appropriate, Looked After Children reviews.

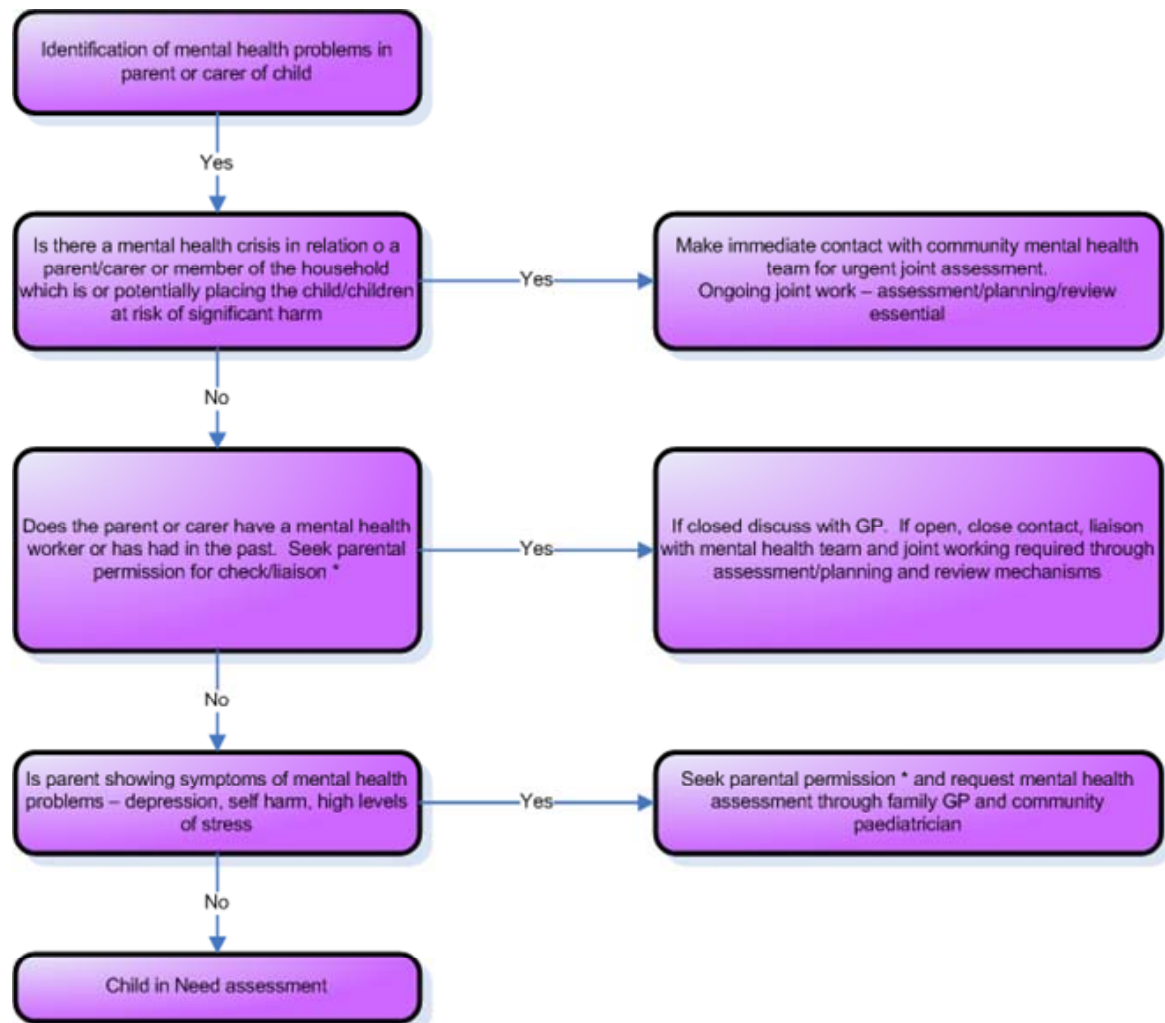
Similarly child care professionals should also attend the relevant CPA meetings and hospital discharge meetings in appropriate cases. Minutes of these meetings should be provided. In all joint cases regular liaison between the key professionals is essential.

Checklist for Mental Health Staff



* If a parent refuses to give consent then this must be discussed with the supervisor and the agency's child protection lead officer to determine a way forward

Checklist for Children's Social Services Staff



* If a parent refuses to give consent then this must be discussed with the supervisor and the agency's child protection lead officer to determine a way forward

MENTAL HEALTH ACT 1983

Summary of Sections

The Mental Health Act 1983 has been amended and will be known as the Mental Health Act 2007. Due to be operational in October 2008. The Principal Sections have not changed. The following is a 'Brief Summary Guide' to the main Sections of the Act, which allow people to be detained in hospital or elsewhere, against their will. This guide is only intended to be a 'QUICK AND READY GUIDE TO THE CURRENT ACT'.

With the introduction of the new Act in 2008, the 'Approved Social Worker' (ASW) role will be opened up to other health professionals, who will be known as an 'Approved Mental Health Professional' (AMHP).

SECTION 2:

Allows compulsory admission and detention for assessment, or assessment followed by treatment for mental disorder, for up to 28 days. Section 2 cannot be renewed, but can be converted to a S3

Statutory Forms - two medical recommendations, one of the doctors should have had previous acquaintance with the patient (usually the GP) the other a doctor who is approved under S12 (2) of the Act. An application form is completed by an ASW. The patient's nearest relative may also make an application, however this is very rarely done.

The section may be discharged by the Registered Medical Official (RMO) at any time during the 28 days. The patient has the right to appeal to the Mental Health Review Tribunal (MHRT) or to the Mental Health Act (MHA) Managers, who also have the power of discharge. The patient may agree to have treatment; however he/she can be treated, for their mental disorder, without their consent if necessary.

The patient can be granted S17 leave by the RMO.
This section is the most commonly used detention order in England and Wales.

SECTION 3:

Allows compulsory admission for Treatment for up to 6 months. Renewable for 6 months in first instance, thereafter periods of one year.

Statutory Forms - two medical recommendations, one of the doctors should have had previous acquaintance with the patient (usually the GP) the other a doctor who is approved under S12 (2) of the Act. An application form is completed by an ASW. The patient's nearest relative may also make an application.

The section can be discharged by the RMO at any time during the 6 month period. The patient has the right to appeal to the MHRT or to the MHA Managers, who also have the power of discharge. Patients can be treated for their mental disorder, with or without their consent, for the first 3 months. Thereafter consent must be given, or a Second Opinion Appointed Doctor requested in order for treatment to continue.

The patient can be granted S17 leave by the RMO.

SECTION 4:

Allows compulsory admission and detention for assessment in an emergency situation. S4 lasts for up to 72 hours. Cannot be renewed, usually converted to S2. Only used when situation does not allow time to wait for another doctor to complete the second medical recommendation

Statutory forms - one medical recommendation and an application by an ASW, or the nearest relative.

No right of appeal.

S17 Leave of Absence not applicable as person is detained for an emergency assessment.

SECTION 7:

A Guardianship Order enables patients to receive community care where it cannot be provided without the use of compulsory powers. Often used for elderly patients, or persons lacking capacity. Establishes a framework for working with a patient in the community with the minimum of constraint.

Initially for 6 month period, renewable in first instance for 6 months, thereafter one year intervals.

Statutory Forms - two medical recommendations, one of the doctors should have had previous acquaintance with the patient (usually the GP) the other a doctor who is approved under S12 (2) of the Act. An application form is completed by an ASW. The patient's nearest relative may also make an application.

Right of appeal to the MHRT only

SECTION 25A:

Order which allows for the supervision of certain patients who have been detained in hospital for treatment (S3) and ensures they receive after-care services provided under S117.

Initially 6 month period, renewable in first instance for 6 months, thereafter one year intervals.

The order can be terminated at any time by the Clinical Registered Medical Officer (CRMO). The patient has the right of appeal to the MHRT.

SECTION 135:

S 135(1) - Warrant issued by Magistrates Court to Search for and Remove person suspected to be suffering from mental disorder, neglect or unable to care for self. Warrant obtained by ASW and authorises police, accompanied by ASW and doctor to forcibly enter person's premises.

S135 (2) - Warrant issued by Magistrates Court which allows for retaking of a detained patient who has gone AWOL. Police or officer of Trust can apply for warrant.

No right of appeal. Non renewable

SECTION 136:

Order used by police to remove to a place of safety, for assessment, any person thought to be mentally disordered and who is found in a public place. Lasts for up to 72 hours. Person can be released; admitted informally or detained under the Act.

No right of appeal. Non-renewable

SECTION 17:

Leave is defined as any excursion, for ANY period of time, which takes place either within the hospital grounds, or outside the hospital grounds. Only the patient's RMO can authorise leave of absence, and, if appropriate, impose certain restrictions and conditions on the leave. Leave is usually granted for short periods initially and gradually builds up to overnight/weekend leave as the patient progresses.

A patient who fails to return to hospital following S17 leave may be brought back under S135 (2).

Leave of absence can be revoked by the RMO at any time.

OTHER ORDERS:

In addition to the above detention orders there are emergency 'holding powers', Section 5(4) Nurses holding power (up to 6 hours) and Section 5(2) Doctors holding power (up to 72 hours).

There are also a number of Court Orders which may also have certain restrictions attached to them – patients on these orders will normally be detained on one of the more secure wards/units of the Trust.

(MHAGenMENTAL HEALTH ACT 2007.doc)

CHILDREN, FAMILIES AND EDUCATION DIRECTORATE CHILDREN'S SOCIAL SERVICES

CHILDREN IN NEED MATRIX

Introduction - the CHIN Matrix is part of CFE's Eligibility and Threshold Criteria for Children's Social Services and is designed as a tool for DIATs. The primary purpose of the Duty and Initial Assessment Team is to determine where social work intervention is required to ensure a child's safety or to change behaviour that is leading to family breakdown. Wherever possible Children's Social Service will intervene before the child is at risk of significant harm.

Purpose of the Matrix - the Matrix is a tool to help determine thresholds and inform the judgments that Duty Managers have to make when deciding which Children in Need cases meet the CSS threshold for early intervention and which should be referred elsewhere and/or closed. It is also intended to introduce greater consistency in decision-making across the County.

It is important to remember that it is accepted that all vulnerable children could potentially benefit from a social work intervention. The Matrix is not about whether vulnerable children could benefit from a social service intervention but about whether the level of their need is high enough to justify the commitment of CSS resources.

Where practicalities such as team capacity or availability of pathways out to other services undermine this process they should be reported immediately to the District Manager.

Format of the Matrix - The Matrix deliberately uses the Assessment Framework domains to avoid confusion and attempts to identify the level of key vulnerability factors such as domestic violence, mental health problems, substance misuse etc. It is recognized that there is no one element that will determine the outcome, as the level of vulnerability will be different in each case. The Matrix assumes that it will usually be a combination of criteria that will determine the level of concern rather than any one factor.

Other children – children who have a statutory right to an assessment or services are not included in the Matrix as they are subject to other arrangements as set out in *Management of referrals (appendix 1)*, *Specialist Disabled Children's Service Criteria (appendix 2)*

- Children who are or who will be privately fostered
- Disabled children and their carers
- Young carers
- Young people under 21 who have left care
- Homeless young people 16-21
- Intentionally homeless families

Key Principles - the Matrix is constructed on the basis of the following fundamental principles:

- CDS will make every effort to ensure that referrers (particularly professional referrers) provide sufficient information
- If necessary CDS will return the inter-agency referral form to a professional referrer to ensure it is completed adequately
- If an initial assessment is required it will be completed within 7 working days from receipt of the referral in the DIAT
- This will include a visit to the child
- Cases will not be closed unless there is sufficient information to inform this decision. Reasons for closure will be recorded.
- Duty Managers and staff are competent and confident about identifying child protection cases;
- Districts have either identified pathways out of Social Services for inappropriate or low/medium priority cases or identified that there is a gap in service that needs to be filled as part of Kent's Local Children's Trust Commissioning Strategy
- That there are systems in place to ensure that duty managers know the status of referrals at all times;
- Permanency planning (including Kinship Care) is always given first consideration

Duty Systems - Duty Teams are required to have systems in place that enable managers to operate a 'triage' system i.e. that priorities are kept under constant review and that the timescales required by the DH Framework for Assessment of CHIN and their Families is adhered to.

Mandatory reporting - if a DIAT cannot work to the above principles or process for any reason this must be recorded and formally brought to the attention of the District Manager as part of the Risk Management arrangements.

Recording - the reasons for the decision in each case must be recorded and kept with the case papers. In addition, a formal notification of the decision must be sent to the professional referrer together with the reasons using the appropriate template letter.

The Children in Need Matrix

Vulnerable children Low level needs (Primary prevention – Tier 1)	Vulnerable children Moderate needs (Early intervention – Tier 2)	Vulnerable children High needs (Treat as CHIN – tier 2.5)	Child in Need Very high needs (High risk – tier 3)	Child in Need Child at risk (Very high risk – tier 4)
<ul style="list-style-type: none"> • Children are vulnerable but not 'in need' as defined by the Children Act 1989; • No requirement for a core assessment but, if possible, should be offered advice, information and redirection to other sources of assistance; • Social Services help is not essential to the monitoring or maintenance of the child; • Collaboration with other agencies to develop local preventative services. 	<ul style="list-style-type: none"> • Families experiencing difficulties where improvements may be desirable but there is no acute risk at present • Social work intervention could be helpful if available. • Support may be provided through community services to which families need to be sign posted. • Priority for joint planning and commissioning of community services. 	<ul style="list-style-type: none"> • There are identifiable factors, which indicate that considerable deterioration is likely without support. 	<ul style="list-style-type: none"> • A reasonable standard of health and development is unlikely to be maintained without Social Services support. The child may move into the urgent category without the provision of services. • There is serious family dysfunction, a child is beyond control, no person is able to exercise parental responsibility or the child is abandoned, trafficked or rejected 	<ul style="list-style-type: none"> • There is a high level of need, serious concerns about the care, health or development of a child and the child is likely to suffer significant harm.

Area of Need	Low level concern	Moderate concern	High concern (tier 2.5)	CHIN (tier 3)	CHIN (tier 4)
<p>Child's health and development needs</p>	<ul style="list-style-type: none"> • Re referral of recently closed cases with no new information. • Parent/carer curtailing child's growing independence. • Limited peer relationships. • Identified learning difficulties and/or disabilities – School Action • Overweight/underweight/enuresis • Low self esteem that might lead to bullying • Poor punctuality/late for school • Intermittent school absences • Poor concentration/not achieving potential • Under stimulated • Smoking/using alcohol • School reporting low level behavioural incidents 	<ul style="list-style-type: none"> • Not achieving key stage benchmarks • Homeless care leaver over 21 • Low level anti-social behaviour • Defaulting on some immunisation and health checks • Experimenting with drugs • Starting to engage in criminal behaviour • Identified learning difficulties and/or disabilities at School Action Plus or Statement of SEN • Poor attendance at school or education setting • At risk of exclusion from school or education setting • Child has serious behaviour difficulties resulting from chronic health or development problems or learning difficulties • No identified school or education placement 	<ul style="list-style-type: none"> • Cannot cope with anger, frustration or upset • Moderate neglect • Parents relationship problems impacting on child • Disruptive/challenging behaviour in school/community/home • Persistent absence from school or education setting (i.e. misses more than 20% of school sessions) • Risk of permanent exclusion 	<ul style="list-style-type: none"> • Child involved in serious substance misuse or offending behaviour • Child has chronic mental health problems that impact on child, e.g. <ul style="list-style-type: none"> • Depression • Eating disorders • Self harming • Other MH diagnosis • Permanently excluded or serious risk of exclusion • Goes missing/risk taking activity • Children with Statement of SEN identifying complex concerns excluded from special schools, including independents schools, with no alternative pathway identified. • Persistent non-attendance at school or education setting. 	<ul style="list-style-type: none"> • Child suffered or at serious risk of significant harm • Child being trafficked or prostituted or at high risk • Child has acute mental health needs that impact on safety/care of child such as acute self harming.

Area of Need	Low level concern	Moderate concern	High concern (tier 2.5)	CHIN (tier 3)	CHIN (tier 4)
<p>Parenting Capacity</p>	<ul style="list-style-type: none"> • Parental engagement is poor • Parents require advice on parenting • Some health problems • Parents relationship under pressure • Parents need advice re child development, behaviour 	<ul style="list-style-type: none"> • Inconsistent emotional responses to child • Provides inconsistent boundaries • Difficult to engage • Struggling to provide adequate care • No effective boundaries • Parent failing to ensure child's engagement in education 	<ul style="list-style-type: none"> • Some concerns about parents ability to keep children safe • Teen pregnancy • Anti-social behaviour • Domestic violence & the child is not present • Cannot control child's behaviour 	<ul style="list-style-type: none"> • Domestic violence and the child is present or affected • Parental disability, mental health or substance misuse problems where concerns are raised about parents ability to attend to the basic needs of the child • Professionals have serious concerns re parenting • Attachment problems – highly critical or apathetic to child • Chronic self harming behaviour • Disclosure of historical sexual abuse where perpetrator no longer present • Child previously looked after or previous request that child be looked after • Child has been subject of 3 CHIN referrals during the year 	<ul style="list-style-type: none"> • Actual or risk of extreme domestic violence between parents/carers • Acute mental/physical illness of parent/carer • Serious substance misuse of parent/carer with evidence of immediate risk to child • Parent/carer unwilling or unable to cope with caring for disabled child • Parent/carer does not meet physical or mental health needs of child • Parents unable to care for previous children

Area of Need	Low level concern	Moderate concern	High concern (tier 2.5)	CHIN (tier 3)	CHIN (tier 4)
<p>Family & Environment</p>	<ul style="list-style-type: none"> • Temporary housing • Limited formal education • Low income • May be new to area • May not access universal services adequately • Dispute over contact arrangements • Threat of eviction • Rent arrears 	<ul style="list-style-type: none"> • Lack of positive role models • Poor relations with extended family • Socially isolated • Inadequate housing • Poor skills/unemployed • Serious debts/poverty • Siblings or parents in custody 	<ul style="list-style-type: none"> • Domestic violence but child not present • No effective support systems • Unhelpful involvement from extended family • Chronic unemployment • Extreme poverty • Very poor housing • Socially isolated • Inadequate supervision 	<ul style="list-style-type: none"> • Families with chronic history of abuse and neglect 	<ul style="list-style-type: none"> • Child exposed to immediate danger • Schedule 1 offender is posing actual or potential risk to child