



# **ASSESSING THE NEEDS OF MENTALLY ILL PARENTS AND THEIR CHILDREN**

**LSCB Joint Protocol between Children & Young People's  
Services and  
Adult Mental Health Services**



Haringey **NHS**  
Teaching Primary Care Trust

Barnet, Enfield and Haringey **NHS**  
Mental Health NHS Trust

# ASSESSING AND WORKING WITH MENTALLY ILL PARENTS AND THEIR CHILDREN

## LSCB Joint Protocol

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## **1 Aim**

- 1.1 To facilitate a cross agency process for assessing and working with mentally ill parents and carers and their children.
- 1.2 To ensure the delivery of a safe and effective service.

## **2 Key Objectives**

- 2.1 To provide a multi-disciplinary and multi-agency package of support for parents or carers with mental health difficulties to enable them to be effective parents/carers.
- 2.2 To support parents to minimise any adverse effects of their mental health difficulties on their parenting/caring capabilities.
- 2.3 To ensure that all professional intervention across adult's and children's services is sufficiently child focussed.
- 2.4 To recognise the circumstances where parental mental illness does significantly impair parenting and ensure that professional intervention achieves safe outcomes for children.

Note: The term mental illness in this document refers to:

- Significant, acute and or enduring mental illness

## **3 Summary**

- 2.1 Child orientated teams (i.e. Children & Families social workers) should seek to identify if a parent has a mental health difficulty.
- 2.2 Adult orientated teams (i.e. Adult Mental Health Services) should always identify if there are children living with or dependant on their client. A 'child' is defined in the Children Act 1989 as anyone under the age of 18 years).
- 2.3 Both areas of service provision require the use of routine enquiry and systematic assessment. (Appendices 5 and 6)
- 2.4 If there is any concern that a child's needs are not being met, then consideration should be given to determine what further interventions are required. The type of response and assessment will depend on the level of need identified. (Appendix 3)
- 2.5 Links with Primary Care and Primary Care teams should be maintained to support the welfare of the child and parent/carers in collaboration with other agencies.

## **4 Context**

- 4.1 This protocol is informed by:
  - The Children Acts 1989 and 2004
  - Framework for the Assessment of Children in Need and Their Families (DoH 2000)

- Working Together to Safeguard Children (2006)
- Supporting Parents, Safeguarding Children (CSCI 2006)
- London Child Protection Procedures
- Mental Health Act 1983 and Code of Practice
- Social Exclusion Unit Report 2004
- Children & Young People's Strategic Partnership Information Sharing Protocol

**4.2** It particularly draws on the concepts laid out in the Children Act 2004 relating to the need for inter-agency governance, integrated strategies, integrated processes and integrated frontline service delivery.

## **5 Principles**

**5.1** Children's needs are paramount

**5.2** Children's needs are best met when parents are supported.

**5.3** Parents with mental illness have the right to be supported in fulfilling their parental roles and responsibilities. Children's and adults' teams will need to talk to each other in order to plan and deliver the services that parents have a right to receive.

**5.4** Children have the right to be protected from harm and to receive services to help meet their needs when their health or development is at risk.

**5.5** Parents with mental illness and their children are one of the groups most likely to be excluded from accessing services and community resources (SEU 2004). This is likely to be further exacerbated if the family are from a minority ethnic group. Services need to work to improve unequal access, and ensure that services are truly needs-led.

**5.6** Children's outcomes are more likely to be met and risk is reduced when information is shared effectively across agencies and when multi agency and multidisciplinary working is effective.

**5.7** While many parents with mental health and or substance misuse problems successfully care for their children with the support of family/friends, some children's life chances may be limited as a result of those factors and health professionals need to consider this possibility for all service users with children.

**5.8** There may be occasions when a parent/carer with mental health difficulties does not suffer any 'severe and enduring mental illness' and has no formal diagnosis of mental illness. Professionals should still be alert to any signs of poor parenting and any difficulties for these parents in safeguarding and promoting the welfare of their children. For those parents with borderline traits of a more serious mental illness, consistent monitoring and ongoing review of their level of vulnerability and affects on their parenting capability would be essential.

## **6 Practice standards**

**6.1** Parents should be able to and/or be supported to be able to nurture and enable their children's social and emotional development, in keeping with their chronological and developmental needs.

- 6.2** The needs of mentally ill parents should be defined as including those occasioned by parenting, as well as by the adults' own personal needs, e.g. personal care of the child; preparation of meals and drinks; attending to the child's health needs; parental involvement in indoor and outdoor play; support in education.
- 6.3** Assessments and care plans should be inter-agency in their approach. They should have a clear focus on meeting the needs of the child and in supporting the parent.
- 6.4** Parenting needs should also be seen as tasks that do not directly involve the parent, but support their parenting choices, e.g. providing childcare while a parent rests.
- 6.5** When a referral to Children and Families is made to consider an assessment of a child's needs, parents and children (where appropriate) need to be informed of the referral and their consent obtained to contact other agencies. If a referral is made where there is likely or actual risk of harm to a child, consent is not required.
- 6.6** Children's social work teams should identify a member of their team who is named as the lead for adult mental health. Adult mental health teams should identify a member of their team who is named as the lead for children. The details of these team members should be widely known, in order to aid case and process discussions.
- 6.7** Parents and children (where appropriate) should receive copies of assessments in formats accessible to each individual.
- 6.8** Adults and children (where appropriate) should always be advised as to how to make representations or complaints about any part of the assessment and care planning process and be supported should they wish to do so.

### **Children & Families**

- 6.9** Social workers should routinely enquire and record whether a parent has a mental health problem at the point of initial contact. This should include known history, previous treatments and descriptions of symptoms, of thoughts, feelings and behaviours. (See Appendix 5 for guidance).
- 6.10** A decision should be made about whether the child is potentially a child in need, or a child in need of protection within the terms of Haringey's threshold criteria within 24 hours of a referral.
- 6.11** If it is thought that a parent may be experiencing a mental health problem consideration should first be given to referring any concerns to the patient's GP. Where the adult's difficulties are deemed to be significant, threatening safety and/or the person is previously known to Adult Mental Health Services, then referral to the Haringey Mental Health Services should be considered.
- 6.12** If a child is potentially 'in need' as well as a parent experiencing significant mental health difficulties, a referral should be made to the Mental Health Trust, and arrangements made for a joint initial assessment. This should be led by MHT staff, who should take responsibility for contacting the family.
- 6.13** If a child is thought to be at risk of suffering significant harm and a parent is thought to be experiencing significant mental health difficulties, child protection (section 47) processes should be used. The Children & Families social worker will take the lead professional role in joint assessment with the MHT.
- 6.14** The Children & Families Referral and Assessment Team will determine what kind of assessment is necessary within 24 hours of receiving the inter-agency referral record. This

record will include questions as to whether the consent of the service user has been sought and that they are aware of the referral.

## **Adult Mental Health**

- 6.15** Mental Health workers should routinely record whether there is a child in the family. The worker should ask routine questions at their initial contact that consider whether and how the adult is able to meet the needs of the child and carry out their parenting responsibilities. (See Appendix 4 for guidance)
- 6.16** When a client has a child, the mental health worker should identify existing the child-based services working with the family (health visiting, school nursing, nursery, school, children's centre). They should then actively consider the need for collaborating with these services in the knowledge of and with consent from their adult client. If it is thought that the child/family need additional support or help then an Assessment should be completed and sent to the appropriate Children and Families Referral & Assessment team. Further joint work should be led by the mental health worker unless the child is felt to be at risk. Guidance on the type of response for particular levels of need is detailed in Appendix 3.
- 6.17** When there are concerns about a child's welfare and/or when it is thought that the child is likely to be in need of protection from harm, an immediate referral to the Children & Families Referral & Assessment Team must be made, usually in the knowledge of the adult client. Consent from the parent/carer is not required. Arrangements for joint working and care planning should be made, with the children's social worker taking the lead.
- 6.18** When it is thought that additional children's services are not required, the mental health worker should carry on with their usual assessment and care planning process. This should always include frequent and active consideration of whether the child's needs are being met and if further contact with Children & Families is required.
- 6.19** Where a child is thought to be suffering with significant emotional difficulties, consideration should be given to discussing and consulting with Child & Adolescent Mental Health Services (CAMHS) in Haringey, proceeding to a referral when necessary in the knowledge and with the consent of the parent/carer.
- 6.20** Mental health workers must ensure that their care planning includes explicit details about issues and interventions required to help their clients in their parenting role. There should be explicit details of agreed plans in regard to the client's child in the event of a mental health crisis, within the Crisis and Contingency section of the CPA (Care Programme Approach) care plan. Children should be given clear information about who to contact in the Mental Health Trust if they become worried about their parent.
- 6.21** MHT care plans should detail who in the team is responsible for helping the adult client talk with their child about issues arising from the mental health difficulties.
- 6.22** **MHT Inpatient Services:** When a parent needs inpatient mental health treatment, the BEH-MHT child visiting policy should be used. In addition to this policy, someone on the ward should be identified to talk with the adult client about issues and anxieties that will be present as a result of their parent/child separation.
- 6.23** When a parent has been receiving mental health inpatient treatment, children's services should be invited to discharge planning meetings prior to discharge, and joint assessment procedures agreed according to level of need. This should be incorporated into existing discharge planning processes (including informal, CPA and section 117) when appropriate.

## **7 The Initial Assessment**

- 7.1 An initial assessment should be completed within 7 working days of referral to Children & Families, who will take responsibility for co-ordinating the process. The children's social worker is expected to see the child and complete the assessment documentation. The MHT worker should complete their assessment forms.
- 7.2 The initial assessment should:
- Identify the core needs of the mentally ill parent or person in caring role.
  - Explore the degree of permanency of the parent's mental illness.
  - Identify the child's developmental needs, and the parents' capacity to meet those needs within the context of their environment.
  - Take account of known variations in the need for assistance, such as additional support during school holidays, at weekends, etc.
  - Agree a joint action plan with the parent(s) and child (if appropriate) which identifies the care package to be provided, responsibility for provision and timetable for review. Clear links between child care procedures and mental health procedures (i.e. Care Program Approach) should be apparent.
  - This plan should include contingencies such as fluctuating medical conditions, hospitalisation of parent or child, and partner's absence, so that should any of these eventualities occur a reassessment is not required, and prior authorisation of services has been obtained.
  - Decide whether a full/core assessment is required.

## **8 The Core Assessment**

- 8.1 A full/core assessment should be carried out when:
- The needs of the parent are complex;
  - There is a risk of significant harm to a child in the family;
  - The adult's impairment or illness is stable, but the child's/children's needs are complex.
  - The absence of a full/core assessment is likely to lead to a re-referral.
  - Three or more initial assessments have been carried out within the last 12 months.
- 8.2 The core assessment is an in-depth assessment of need, which should be carefully planned and involve all relevant agencies. It should be completed within 35 working days from commencement
- 8.3 At the start of a core assessment, a planning meeting should take place between a member of staff from each service, the family and relevant professionals from other agencies who might be asked to contribute to the assessment process. At this meeting, a recommendation should be made as to the most appropriate service to take the lead and a written agreement completed with the family. When a full assessment is being carried out under child protection (section 47) arrangements, a strategy meeting will occur within 48

hours, and an Initial Child Protection Conference will be arranged within the first 15 days. The Children & Families social worker will always lead child protection investigations.

**8.4** A core assessment should be led by adult mental health workers when:

- The parent has a significant, acute, and enduring need complex, and requires a package of care to support them in their parenting role, in the absence of child protection concerns.

**8.5** A core assessment should be led by Children & Families when:

- There is a risk of significant harm to a child in the family.
- The adult's impairment or illness is stable, but the child's/children's needs are complex.

**8.6** At the end of a core assessment, a care plan should be jointly agreed between the Children & Young People's service and the Mental Health Trust. This should be recorded in both care plans. Both Team Managers should support and agree package before presentation to the Adults' Funding Panel.

## **9 Young Carers**

**9.1** 'Young carers are children and young persons under 18 who provide, or intend to provide, care, assistance or support to another family member. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling,, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care, support or supervision. Factors which influence the extent and nature of young carers' tasks and responsibilities include the illness/disability, family structure, gender, culture, religion, income, and the availability and quality of professional support and services'.

(Ref: Becker, S. (2000) 'Young Carers', in Davies, M. (ed.) The Blackwell Encyclopaedia of Social Work. Oxford: Blackwell Publishers Ltd, p. 378).

**9.2** When a young person is undertaking any caring role within the family the first consideration should be whether or not the adult is receiving the necessary services. Referrals to Children's Services in relation to young carers should therefore automatically be referred to the Community Mental Health Teams and a joint assessment carried out, led by the mental health worker. Any young carer is entitled to an assessment of their ability to care under section 1(1) of the Carers (Recognition and Services) Act 1995 and the local authority must take that assessment into account in deciding what community care services to provide for the parent.

**9.3** When a child is acting in a young carer role, consideration should be given to referral and contact with the Haringey Young Carers' Service in discussion with the parent and child.

## **10 Care Packages**

**10.1** Packages of care will be provided through the purchasing mechanisms and contracts available to the mental health workers. Staff in services providing packages that relate to children should be subject to police checks.

**10.2 Direct Payments:** When service users wish to purchase their own care packages via 'direct payments', the staff member from the MHT should undertake this component of the assessment. The assessor should then consider referring to the Social Services Direct Payments Advisor for specialist advice.

**10.3 Finance Administration:** The following process is designed to formalise joint responsibilities and sharing of costs whilst ensuring that there is sufficient flexibility to meet identified needs.

- Funding of joint packages of care between Adult Mental Health teams and the Children & Young People's Service will be overseen by the Children's Complex Care Planning Panel. Referrals to the panel should follow the Haringey Panel Procedures.
- Funding will be authorised by the Service Manager, Children & Families, who will attend the meeting. Agreements will cover:
  - Care packages provided by private and voluntary agencies
  - Care packages provided by cost and volume contract providers
  - Care packages provided by the Federation of Voluntary Care Providers
  - Care packages funded under Direct Payments arrangements

**10.4** Consideration will be given, case by case, and based on assessed need, to whether or not funding will be allocated.

**10.5** If a child is accommodated as part of the changing circumstances of the family, this will not affect the source of funding of the package, unless the child is accommodated for a period in excess of six weeks and there is no plan to return the child to the adult service user's care in the near future.

**10.6** The panel will then have to review the funding package and consult with the Service Manager, Children & Families.

**10.7** If the child has a Child Protection Plan, any additional services required as part of the plan should be identified by the core group and purchased separately by the relevant children's team.

## **11 Review**

**11.1** Time-scales for review will be identified at the point that a joint action plan or joint care plan is agreed.

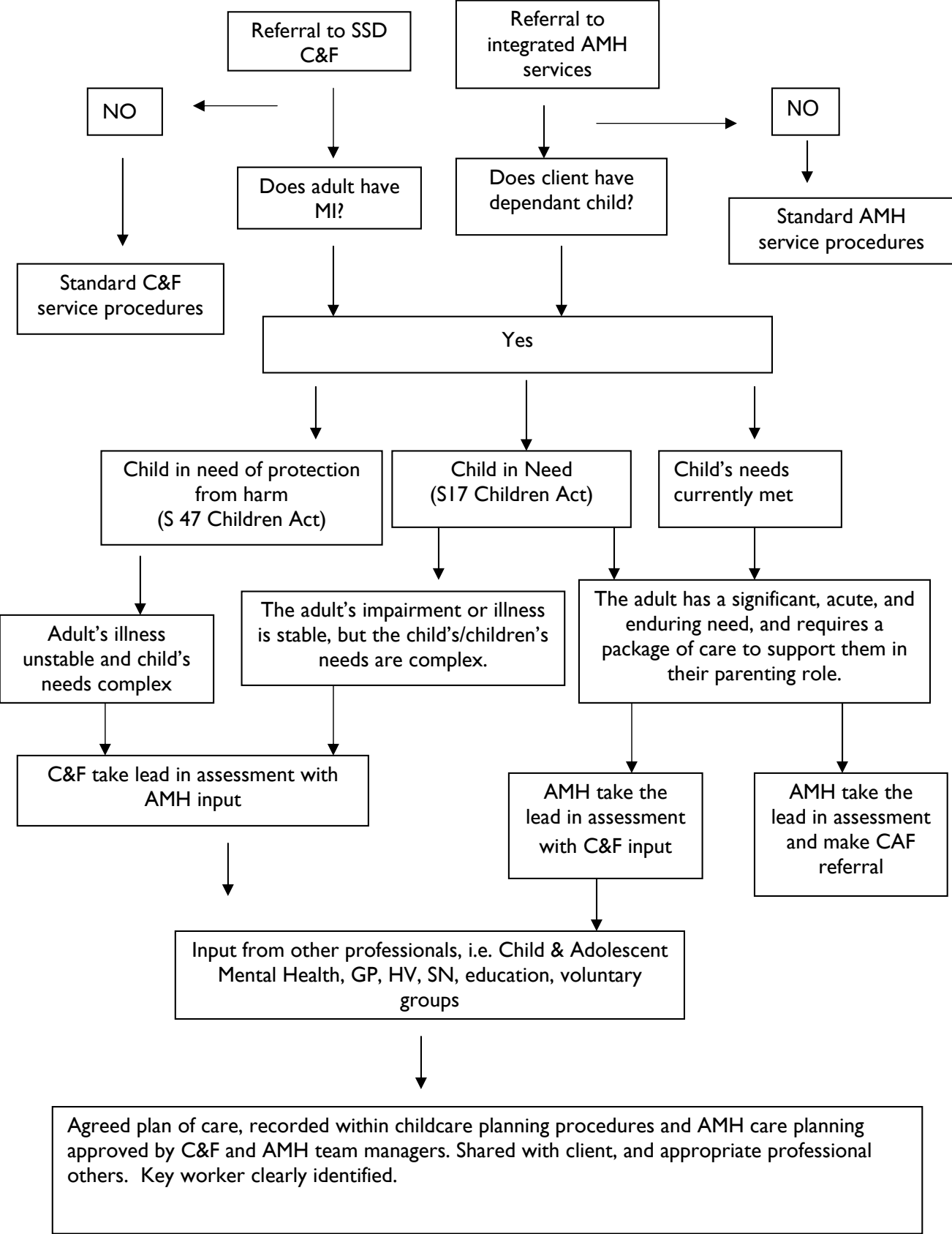
**11.2** The review process should take account of the fact that the needs of people with mental health problems constantly change in both foreseen and unforeseen ways. A timescale should therefore be set in response to the particular circumstances surrounding the adult service user's needs through clinical and funding reviews of:

- The changing needs of the child, and
- The complexity and size of the package being provided.

**11.3** There should always be the flexibility for a case to be re-reviewed at any time or re-opened speedily if it has been closed.

**11.4** Should the priority for review differ between the two services then a shorter timescale will be adopted.

# Appendix One: Care Pathway for Assessment of Mentally Ill Parents & Children in Need



## Appendix Two: Risk and Protectors guide

FACTOR	RISK	PROTECTOR
Parent/child relationship	Distant/discordant	Warm/mutual
Parenting	Lax/hostile/no control	Positive
Parental relationship	Distant/violent	Mutually supportive/ co-operative
Parental health	Parents ill	Parents well
Sibling/peer relationships	Absent/oppressive	Warm and supportive
Socio-economic resources	Material hardship	Financially secure
Housing	Crowded, unhygienic, insecure	Good, spacious
School	Poor ethos, low support, bullying	Good ethos, supportive
Community	Supports absent, anti-social influences	Support. Child activities
Life events/ experiences	Loss/negative life events	Positive life events/ Achievements praised

(Falkov, A (1998), Crossing Bridges)

## Appendix Three: Summary of levels of concern, indicators and agency response

<b>LEVEL 1</b> Family under stress - child's/young person's health and /or development may be affected	<b>LEVEL 2</b> Child's/young person's health and development is being impaired or there is a high risk of impairment	<b>LEVEL 3</b> Child/young person experiencing significant harm or there is a likelihood of significant harm- at risk of removal from home
<p><b>Family Indicators</b></p> <ul style="list-style-type: none"> <li>▪ Isolated/unsupported carer(s)</li> <li>▪ Parents/carers have emotional or physical health difficulties</li> <li>▪ High number of dependent children in family</li> <li>▪ Parents/carers misuse substances</li> <li>▪ Involvement in criminal activities</li> <li>▪ Contact/residence disputes</li> <li>▪ Experiencing racism</li> <li>▪ Poor hygiene</li> <li>▪ Young carers</li> </ul>	<p><b>Family Indicators</b></p> <ul style="list-style-type: none"> <li>▪ Parents/carers have drug/ substance dependency</li> <li>▪ Families suffering extreme poverty where the basic needs cannot be met</li> <li>▪ Parents/carers have mental health problems</li> <li>▪ Homelessness</li> <li>▪ Some domestic violence incidents</li> </ul>	<p><b>Family Indicators</b></p> <ul style="list-style-type: none"> <li>▪ Parents/carers cannot provide care</li> <li>▪ Care arrangements breaking down/ legal proceedings</li> <li>▪ Serious incident of domestic violence/ several lesser incidents</li> <li>▪ Carers have all the following problems: substance dependency, mental health and domestic violence</li> </ul>
<p><b>Child/young person indicators</b></p> <ul style="list-style-type: none"> <li>▪ Behavioural changes/management difficulties</li> <li>▪ Physical health needs requiring support</li> <li>▪ Developmental delay</li> <li>▪ Additional educational support required</li> <li>▪ Unauthorised absences from school</li> <li>▪ Substance misuse suspected</li> </ul>	<p><b>Child/young person indicators</b></p> <ul style="list-style-type: none"> <li>▪ Emotional/behavioural disorders</li> <li>▪ Teenage pregnancy/parenthood</li> <li>▪ Disabilities</li> <li>▪ Chronic or terminal illness</li> <li>▪ Minor criminal activities</li> <li>▪ Regularly absent from school</li> <li>▪ Previously on the Child Protection Register</li> <li>▪ Statement of Educational Needs</li> </ul>	<p><b>Child/young person indicators</b></p> <ul style="list-style-type: none"> <li>▪ Child/young person is on the Child Protection Register</li> <li>▪ Behaviour puts child/young person at risk e.g. prostitution, self harming, dangerous risk taking or control issues</li> <li>▪ Regularly goes missing from home</li> <li>▪ Temporarily/permanently excluded</li> </ul>
<p><b>RESPONSE: Normally a single agency response is appropriate</b></p>	<p><b>RESPONSE: Normally need for co-ordinated, multi agency assessment and provision of services – Lead Professional</b></p>	<p><b>RESPONSE: Multi agency assessment and provision of services Statutory expectations of key worker</b></p>

## Appendix Four: CHILD NEED AND RISK FORM for ADULT MENTAL HEALTH STAFF

To be completed if adult client has/likely to have dependent children or contact with children

Patient:

Names and ages of children:

Name of assessor

Signature

Date of assessment    /    /

Consider the impact of the client's mental illness on the child/ren identified:								
	YES	NO	Don't know		YES	NO	Don't know	
<b>SYMPTOMOLOGY/BEHAVIOUR OF ADULT MENTAL ILLNESS THAT INVOLVES THE CHILD</b> Also consider risk due to dual diagnosis, unstable symptoms, low level of service use, lack of continuity of care				<b>IMPACT ON EMOTIONAL WELLBEING OF CHILD:</b> e.g. evidence in child of increased fearfulness/anxiety, behaviour difficulties, withdrawn, isolation from peers, parenting behaviour				
<b>IMPACT ON PHYSICAL WELLBEING OF CHILD:</b> e.g. not dressed for the weather, unkempt, not being protected from danger, injury to child				<b>SUPPORTIVE NETWORK NOT AVAILABLE:</b> e.g. single parent, partner with physical/mental illness, low input from extended family, socially isolated				
<b>IMPACT ON COGNITIVE WELLBEING OF CHILD:</b> e.g. poor school attendance, high or low expectations, lack of stimulation				<b>CHILD AND/OR FAMILY KNOWN (or previously known) TO CHILD&amp; FAMILY SOCIAL SERVICES</b>				

These indicators are intended to guide assessment – not to be added up or used to produce a numerical score. Also take account of other relevant information, and the extent to which information is available to you. **The younger the child the higher the risk, and the quicker the intervention/change will be need to be in place.**

### ACTION REQUIRED

1. If you answered **No** to all the questions stop here, unless there is a child under five years old – identify the family's health visitor and/or GP and ensure appropriate level of information sharing. Referral to Children & Families social work teams as a 'child in need' can be considered with client consent.
2. If you answer **Yes**, and there is a concern that the child is actually or likely to be suffering significant harm - discuss with team and/or refer immediately via telephone to your local Children and Families Referral & Assessment Team with or without consent.
3. If you answered **Yes**, and there are no concerns about actual or likely significant harm, the child should be thought of as 'in need', and a consensual referral to your local Children and Families Referral & Assessment team considered.
4. Complete your clinical assessment, recording information in clinical notes
5. Update the **care plan** appropriately, ensuring risk forms are placed in clinical notes. Ensure issue for the child/ren are considered and spelt out in the **CPA** contingency and crisis plan.
6. Consider whether the children are young carers, and complete as appropriate, **Carers Assessment Form**
7. If adult client is an in-patient, use the BEHMHT **Child Visiting Policy**

## **Appendix Five: ADULT MENTAL HEALTH SCREEN FOR USE BY CHILDREN & FAMILIES WORKERS**

- ✓ To be completed for any parent of a child in need or at risk (or adult associating with the child)
- ✓ For child and family workers to assess and refer parents / involved adults who may / have mental health needs to mental health services

Name and DOB of parent / adult:

Full address & code etc. of adult:

Assessor:

Designation:

Date:

Contact details:

	Yes	No	Not known	Action taken / Date
1. Are you concerned about the parent / adult's mental health ? (consider use of GHQ and psychosis screening tool – appendix 7 - to aid this question)				
2. Does the problem appear to be significant or acute?				
3. Does the adult appear to be an immediate risk to themselves or others?				
4. Has the adult had previous contact with or is known to MH services?				
5. Is the child potentially 'in need' as well as a parent / adult experiencing a mental health disorder?				
6. Have concerns been raised by a Primary Care Worker such as the Health Visitor?				
7. Is the child a young carer for an adult who is thought to have a mental health problem				

### **ACTION REQUIRED**

If you answer **yes to question 1, or 2**, record details and consider the possibility of referring the person to their GP

If you answer **yes to question 3** consider immediate contact with emergency services (A&E) or the Haringey MH Intake Team. See appendices for addresses.

If you answer **yes to questions 3 and 4** ensure local mental health services are involved. See appendix for contact list of local MH services.

If you answered **yes to question 5** Consideration should first be given to referring any concerns about the adult to the patient's GP. Where the problem is significant and the person is previously known to Adult Mental Health services, refer to the known Haringey Community Mental Health Team (CMHT) who should take responsibility for contacting the family and leading a joint initial assessment.

If you answer **yes to question 6** refer any concerns to the mother's GP

If you answer **yes to question 7** refer to the local Community Mental Health Team to see if the adult is already known. If they are not register with the local CMHT refer the concerns to the GP. If the adult is already registered with the CMHT or becomes registered following referral to the GP a joint assessment should be carried out led by the CMHT

## Appendix Six: CONTACT DETAILS

### Haringey Integrated Adult Mental Health Services

All referrals should be directed to the referral co-ordinator or Team Leader for Assessment and Treatment. Any problems should be referred to the Service Manager/Clinical Co-ordinator.

<p><b>START</b>  <b>(Short Term Assessment &amp; Recovery Team)</b>                  Based at St Ann's Hospital. Borough-wide intermediate care service with a single duty function  <b>020 8442 6706/6714</b></p> <p>A&amp;E Liaison Psychiatry North Middlesex Hospital  <b>020 8887 2000</b></p>		
<p><b>West Support &amp; Recovery Team</b>                  Kate Marsden Unit                  St Ann's Hospital                  St Ann's Road                  London N15 3TH  <b>020 8442 6456</b></p>	<p><b>Central Support &amp; Recovery Team</b>                  Canning Crescent Centre                  276 High Road                  London                  N22 8JT  <b>020 8829 1000</b></p>	<p><b>Tottenham Support &amp; Recovery Team</b>                  Tynemouth Road Centre                  First Floor                  24 Tynemouth Road                  London N15 4RH  <b>020 8275 4089</b></p>
<p><b>Haringey CAMHS Outreach</b>  <b>020 8365 1375</b></p>	<p><b>Primary Care Mental Health Development team (HTPCT)</b>                    Dorian Cole, Clinical Specialist.  <b>020 8442 6987</b></p>	<p><b>Community Forensic Team</b>    <b>020 8375 6017</b></p>

### **Haringey Children & Families Services for Referring Children In Need and Child Protection**

<p>Referral &amp; Assessment Team                  West Haringey    <b>020 8489 1856/1805/1806</b></p>	<p>Referral &amp; Assessment Team                  East Haringey    <b>020 8489 5402/5403/5404</b></p>	<p>Children With Disabilities  <b>020 8489 3671</b>                    Leaving Care &amp; Asylum Service  <b>020 8489 5842/5852</b></p>
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## Appendix Seven: GENERAL HEALTH QUESTIONNAIRE

Name.....

We want to know how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Have you recently:

1. been able to concentrate on what you're doing?

better than usual (0)    same as usual (1)    less than usual (2)    much less than usual (3)

2. lost much sleep over worry?

Not at all    no more than usual    rather more than usual    much more than usual

3. felt that you are playing a useful part in things?

more so than usual    same as usual    less so than usual    much less than usual

4. felt capable of making decisions about things?

more so than usual    same as usual    less than usual    much less than usual

5. felt constantly under strain?

Not at all    no more than usual    rather more than usual    much more than usual

6. felt you couldn't overcome your difficulties?

Not at all    no more than usual    rather more than usual    much more than usual

7. been able to enjoy your normal day to day activities?

more so than usual    same as usual    less so than usual    much less than usual

8. been able to face up to your problems?

more so than usual    same as usual    less than usual    much less than usual

9. been feeling unhappy or depressed?

not at all    no more than usual    rather more than usual    much more than usual

10. been losing confidence in yourself?

not at all    no more than usual    rather more than usual    much more than usual

11. been thinking of yourself as a worthless person?

not at all    no more than usual    rather more than usual    much more than usual

12. been feeling reasonably happy, all things considered?

more so than usual    same as usual    less so than usual    much less than usual

## **General Health Questionnaire Scoring**

Scoring – Likert Scale 0, 1, 2, 3 from left to right.

12 items, 0 to 3 each item

Score range 0 to 36.

Scores vary by study population. Scores about 11-12 typical.

**Score >15 evidence of distress**

**Score >20 suggests severe problems and psychological distress**

# Appendix Eight: THE PSYCHOSIS SCREENING QUESTIONNAIRE

(PSQ; Bebbington and Nayani, 1995)

## 1 Hypomania

Probe

- Over the past year, have there been times when you felt very happy indeed without a break for days on end?

If yes,

- Was there an obvious reason for this?
- Did your relatives or friends think it was strange or complain about it?

## 2 Thought insertion

Probe:

- Over the past year, have you ever felt that your thoughts were directly interfered with or controlled by some outside force or person?

If yes,

- Did this come about in a way that many people would find hard to believe, for instance, through telepathy?

## 3 Paranoia

Probe:

- Over the past year, have there been times when you felt that people were against you?

If yes,

- Have there been times when you felt that people were deliberately acting to harm you or your interests?
- Have there been times when you felt that a group of people were plotting to cause you serious harm or injury?

## 4 Strange experiences

Probe:

- Over the past year, have there been times when you felt that something strange was going on?

If yes,

- Did you feel it was so strange that other people would find it very hard to believe?

## 5 Hallucinations

Probe:

- Over the past year, have there been times when you heard or saw things that other people couldn't?

If yes,

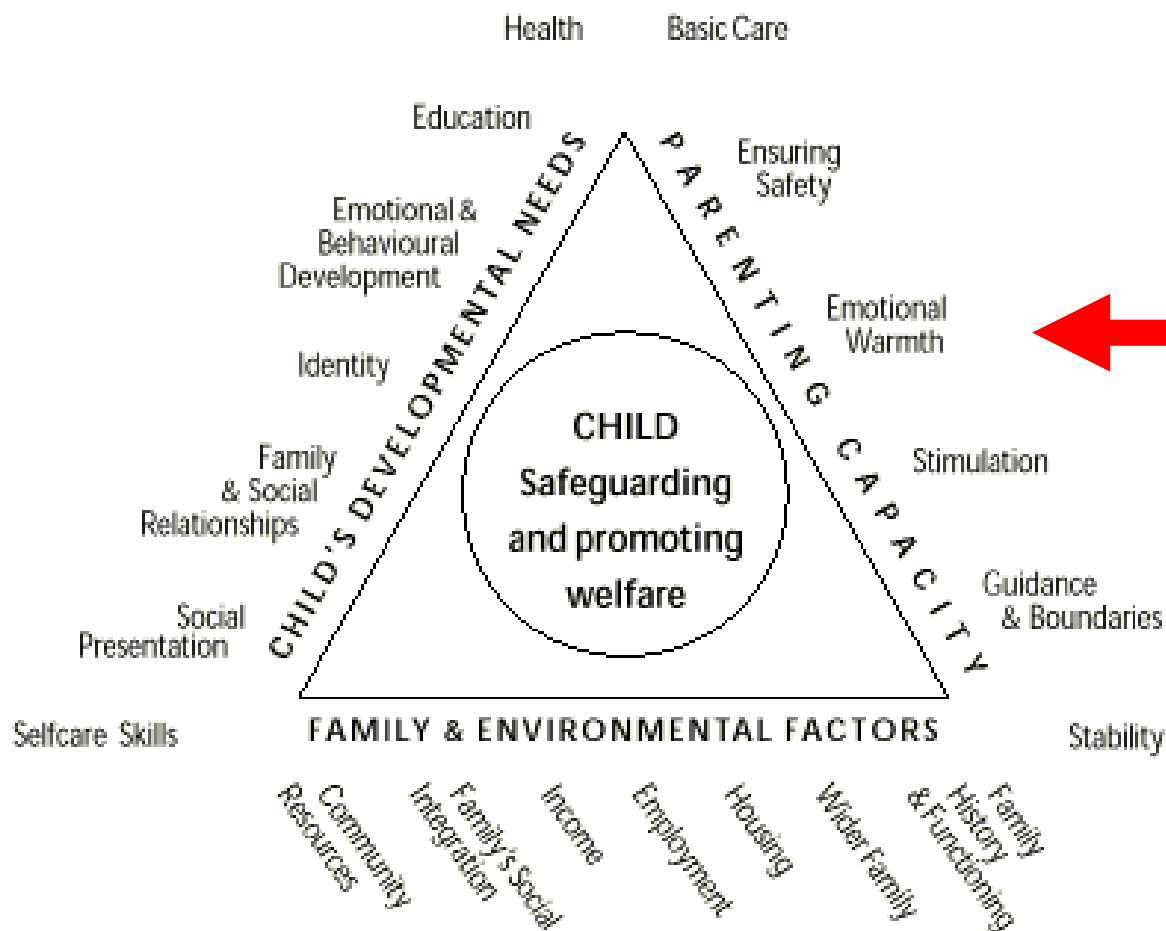
- Did you at any time hear voices saying quite a few words or sentences when there was no-one around that might account for it?

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Taken from article : Prevalence and correlates of self-reported psychotic symptoms in the British population

Louise C. Johns, Mary Cannon, Nicola Singleton, Robin M. Murray, Michael Farrell, Traolach Brugha, Paul Bebbington, Rachel Jenkins, Howard Meltzer British Journal of Psychiatry (2004), 185: 298-305

## Appendix Nine: Relationship between Key Issues in Adult Mental Ill Health and the Parenting Capacity Aspect of the Framework for the Assessment of Children in Need and their Families



### Mental health

- Parent's strengths and coping mechanisms
- Nature, frequency, severity, pattern, timing and duration of MH problem
- Child's exposure to or involvement in behaviours and symptoms
- Dual diagnosis
- Supports, treatment issues, insight and compliance
- Impact on behaviour and functioning
- History