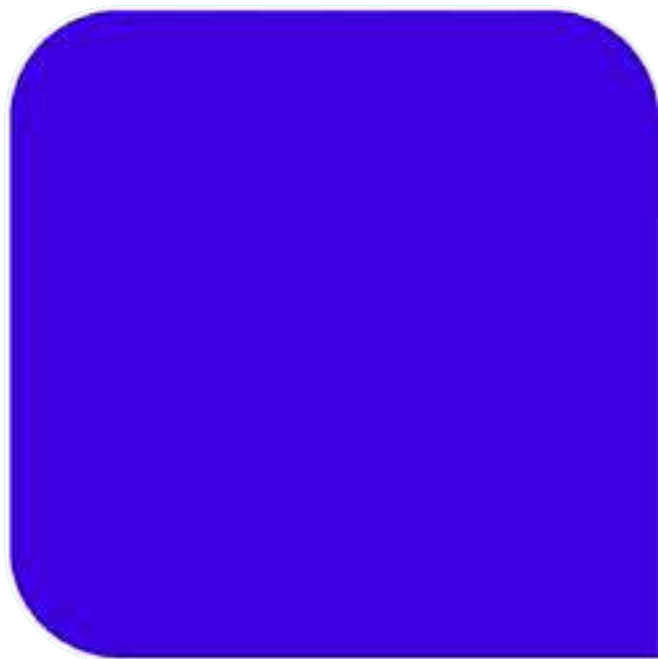
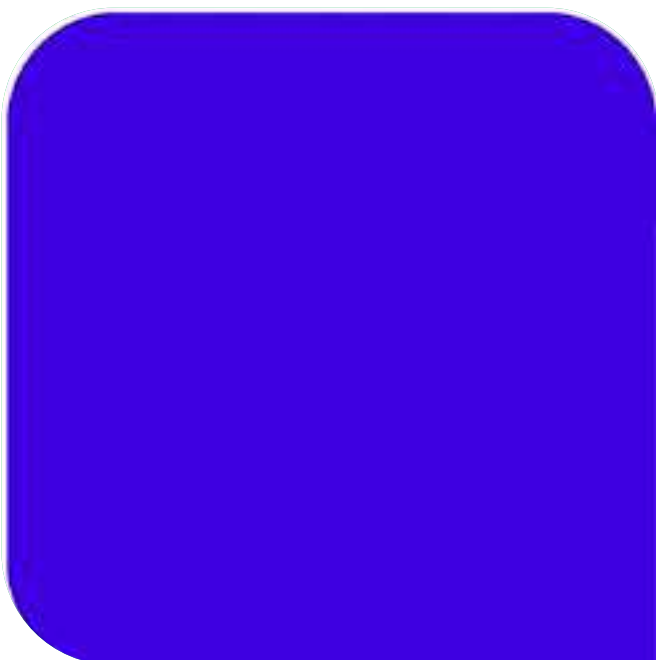




# Think child, think parent, think family: a guide to parental mental health and child welfare



The Social Care Institute for Excellence (SCIE) was established by Government in 2001 to improve social care services for adults and children in the United Kingdom. We achieve this by identifying good practice and helping to embed it in everyday social care provision.

SCIE works to:

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- enhance the skills and professionalism of social care workers through our tailored, targeted and user-friendly resources.

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## About this guide

### Why have we written this guidance?

SCIE was originally commissioned to work in this area following a 2004 Social Exclusion Unit report which identified parents with mental health problems as a group that was sometimes poorly served by health and social care.

### Who is this guide for?

The guide has been written for front-line and managerial staff in mental health and children's services from all sectors. It is also relevant for commissioners, policy makers, those delivering education and training to health and social care staff' and others responsible for workforce development.

People who use services and their carers will find useful information on what they can expect from services and where they can go for more information.

### How was the guide developed?

This is an updated version of the Think Child, Think Parent, Think Family guide, which SCIE first published in 2009. The 2009 version was based on reviews of the published literature from 1985–2005 and a practice survey - a review of existing practice in adult and children's health and social care services - carried out in five sites in England – North Somerset, Birmingham, Liverpool, the London Borough of Southwark, and the London Borough of Lewisham between 2006–2008. The original reports of each review and the practice survey are available on the website.

The original guide was steered by advisory groups consisting of service users and other sector experts.

From 2009-2011, SCIE worked with the original five practice survey sites, and the five Health and Social Care Trusts in Northern Ireland, to put the recommendations of the guide into practice. SCIE supported multi-disciplinary steering groups in each of the sites to develop an action plan, and monitor and evaluate its implementation for two years in England, and for three years in the Northern Irish trusts. This has generated a wealth of good practice examples and resource tools, which are included in the guide, as well as advice on how best to go about implementing the guide's recommendations.

### A note about terms used

We use the term '**parent with mental health problems**' to refer to those parents with a primary diagnosis or need, identified as a mental health problem, mental illness or mental disorder. These parents may also experience other health problems or disabilities, alcohol or substance misuse, learning difficulties or domestic violence. The term includes parents who are known to children's services but do not have a formal mental health diagnosis, and parents who have not come to the attention of secondary mental health services.

It is important to remember that adults caring for children are not always their biological parents. Step-parents, partners and others can have important caring roles in children's lives, and their mental health needs must be taken into account just as much as those of an actual parent. Throughout this guide, therefore, the term **parent** should be taken to apply to all adult carers living with the child.

The term '**children**' is used to refer to everyone 18 years or younger, some of whom will be young carers.

The term '**young carer**' is used to refer to someone under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person which would normally be undertaken by an adult. Young carers undertake a variety of tasks for parents with mental health problems, including advocacy, help with correspondence and bills, liaising with professionals, administering medicines, emotional support and domestic tasks.

Different services use very different language to describe the processes they follow for assessing need and delivering support. However, essentially they all operate a basic care pathway that involves making and receiving referrals, screening clients, assessing need, putting together a care plan and reviewing existing care plans. We have therefore used these terms to describe a generic **care pathway** throughout this guide, based on the assumption that whatever service is providing care and whoever receives it, they will typically go through a process which includes these

## Acknowledgements

This guide builds on the work of the original 2009 version, and we again acknowledge those who worked on it. We would once more like to thank our sponsors, the Department of Health and the Department for Education, for their support.

Our great thanks go to all those people in Birmingham, Lewisham, Liverpool, North Somerset, Northern Ireland and Southwark who have been committed to the work of this project. Their ideas, enthusiasm and effort have created this revised guide, but more importantly have led to changes for the better for local families affected by parental mental illness.

The implementation work SCIE has done would not have been possible without the leadership and support of Nasa Begum (1963-2011), and we dedicate this work to her memory.

## Summary

### Key recommendations for practice

#### **Signposting and improving access to services**

Organisations should develop a multi-agency communications strategy to tackle the stigma and fears that parents and children have about approaching and receiving services. This should be a priority to enable families to get the support they need as soon as possible and should focus on promoting good mental health and wellbeing for all family members.

#### **Screening**

Ensure screening and referral systems and practice routinely and reliably identify and record information about which adults with mental health problems are parents, or live with children, and which children have parents with mental health problems. This means developing systems and tools in collaboration with parents and young people, to ensure the right questions are asked and the data is recorded for future use.

#### **Assessment**

All organisations need to adapt existing assessment and recording processes to take account of the whole family and train staff in their use. This means developing and implementing 'family' threshold criteria for access to services to take into account the individual **and** combined needs of parents, carers and children. Strategies for the management of joint cases should be recorded where the situation is complex or there is a high risk of poor outcomes for children and parents.

#### **Planning care**

Care planning needs to be flexible enough to meet the needs of each individual family member as well as the family as a whole, and staff should aim to increase resilience and reduce stressors. Allocating an individual budget could provide this flexibility. Increasing every family member's understanding of a parent's mental health problem can strengthen their ability to cope.

#### **Providing care**

Commissioners and providers of care should ensure that they can meet the full spectrum of needs, including the practical priorities of parents with mental health problems and their children. This means developing non-traditional and creative ways of delivering services as a way of targeting families and improving access.

#### **Reviewing care plans**

Reviews should consider changes in family circumstances over time, include both individual and family goals, and involve children and carers in the process.

#### **Strategic approach**

Multi-agency, senior-level commitment is required and we recommend that a 'Think Family Strategy' is developed to implement this guidance and that parents, children and carers are involved in all stages of development.



**Workforce development**

Investment is needed in training and staff development for adult and children's front-line managers and practitioners to support the changes recommended in this guide about how to 'think child, think parent, think family' and work across service interfaces.

**Putting it into practice**

Combining the authority of senior managers and the dynamism of the voluntary sector and users is the most effective way of supporting staff seeking to put whole-family approaches into practice. Embedding the messages into induction, training, supervision and performance management can help promote the work, and altering assessment and recording tools, can prompt people to Think Family.

# 1 Introduction

## What we're dealing with

Parents with mental health problems and their children are a group with complex needs. Not all parents and children will need the support of health and social care services but those that do can find it difficult to get support that is acceptable, accessible and effective for the whole family. This guide identifies what needs to change and makes recommendations to improve service planning and delivery, and ultimately to improve outcomes for families.

Parents with mental health problems need support and recognition of their responsibilities as parents. Their children's needs must also be addressed. Research and government reports have highlighted the extent of the problem:

- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves<sup>1</sup> Of the 175,000 young carers identified in the 2001 census, 29 per cent – or just over 50,000 – are estimated to care for a family member with mental health problems.<sup>2</sup>
- Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90 per cent of parents on their caseload have mental health problems, alcohol or substance misuse issues<sup>1</sup>.
- In a class of 26 primary school children, it is estimated that six or seven children are living with a mother with mental health difficulties<sup>3,4</sup>.

There are important public health implications of not addressing the needs of these families, as parental mental health problems can have an impact on parenting and on the child over time and across generations:

- Between one in four and one in five adults will experience a mental illness during their lifetime.
- At the time of their illness, at least a quarter to a half of these will be parents.
- Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health.
- Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting can impinge on adult mental health.
- The mental health of children is a strong predictor of their mental health in adulthood.
- The two per cent of families who suffer the combined effect of parental illness, low income, educational attainment and poor housing are among the most vulnerable in society<sup>5</sup>

## What parents and children want

In general, parents and children want appropriate understanding and support based on the different needs of individual family members. This support needs to be sustained over time, but should also vary to reflect any change in circumstances<sup>6</sup>.

More specifically, for themselves, parents want:

- more understanding and less stigma and discrimination in relation to mental health problems
- support in looking after their children
- practical support and services
- good quality services to meet the needs of their children
- parent support groups
- child-centred provision for children to visit them in hospital
- ongoing support from services beyond periods of crisis
- continuity in key worker support
- freedom from fear that children will inevitably be removed from them.

For their children, parents want:

- opportunities for children to talk about any fears, confusion and guilt
- opportunities for children to meet adults they can trust, and to participate in activities where they can meet other children
- provision of explanation and discussion about the events and circumstances surrounding the parental mental health problems
- continuity of care and minimal disruption of routines during a crisis (including hospitalisation of parent/carer).

Children and young people want:

- age-appropriate information about the illness and prognosis
- someone to talk to – not necessarily formal counselling
- a chance to make and see friends.

Children and young people taking on a caring role want:

- recognition of their role in the family
- practical and domestic help
- a contact person in the event of a crisis regarding a parent<sup>6</sup>.

A group of young carers in Merseyside<sup>7</sup> came up with the following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems:

1. Introduce yourself. Tell us who you are. What your job is.
2. Give us as much information as you can.
3. Tell us what is wrong with our mum or dad.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know, and what we think. We live with our mum or dad. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live there too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to. **MAYBE IT COULD BE YOU.**

*The above is a synthesis of the findings from four separate studies that appeared in Crossing Bridges (1998)<sup>8</sup> about what parents and children have said they want for themselves and each other*

## The policy context

In recent years, under both the previous government and the coalition, there has been a notable shift in children's and adult social care policy and guidance, which places greater emphasis on the need to support parents in their parenting role. The main policy drivers in England and Wales are set out here.

### No Health Without Mental Health (2011)

The coalition government's outcomes strategy for mental health explicitly looks at mental health across the lifespan, and explores how whole-family approaches can benefit the wellbeing of all family members. The strategy has six key aims:

- 1) More people will have good mental health.
- 2) More people with mental health problems will recover.
- 3) More people with mental health problems will have good physical health.
- 4) More people will have a positive experience of care and support.
- 5) Fewer people will suffer avoidable harm.
- 6) Fewer people will experience stigma and discrimination.

The Think Family agenda is relevant to all of these. No Health Without Mental Health:

- stresses the need to intervene early, and tackle stigma, where mental health problems arise in children; to break the intergenerational cycle of them growing up with mental health problems which then affect their own parenting

- focuses on early intervention with adults with mental health problems
- calls explicitly for whole-family assessments and care plans to promote family and individual recovery
- recognises the crucial, detailed information other family members, including children, have about a person's mental ill health, and the importance, therefore, of listening to all family members when planning a person's care and support
- cites the improved outcomes that whole-family approaches can achieve.

Other coalition initiatives are highly relevant to this agenda. Both the government's Vision for adult social care<sup>9</sup>, and Professor Eileen Munro's review of the child protection system<sup>10</sup> call for a wider family focus to safeguarding children, so that all staff are aware of their responsibilities, and recognise that meeting the needs of family members who may put children at risk benefits the child, the adult, and the family as a whole.

### **Troubled Families initiative and Community Budgets**

In December 2010, the Department for Education launched a new national campaign to try to support 'troubled families': those experiencing multiple social, health, and economic problems. The government estimates there are 46,000–120,000 such families, which at times make very high demands on local services but which can still experience poor outcomes. The aim is that each family will be supported by a single key worker, who will help them engage with services such as education and employment. Other local services will be encouraged to invest in, and benefit from, any savings generated by supporting families earlier and more effectively. This new approach builds on the work of Family Intervention Projects (FIPs) which by March 2010 had supported over 1,800 families (DH figures).

It is worth noting here that whilst many of the families targeted by the FIPs and the Troubled Families initiative are experiencing adult or child mental health issues, the majority of families experiencing parental mental health problems will not be eligible for these services. Organisations therefore will still need to consider how to support those families affected by parental mental health who fall outside of these targeted groups.

The government's plans for Community Budgets also aim to support families with multiple problems. Starting in April 2011, 28 local authorities in England are piloting an approach to tackle barriers to shared funding, in an attempt to provide services more holistically and effectively. Both Community Budgets and the Troubled Families initiative are clearly seeking to generate a context in which whole-family approaches can flourish. At the time of writing, it is too early to judge their success in doing so.

### **[Think Local, Act Personal \(2011\)](#) and [Putting People First: a shared vision and commitment to the transformation of adult social care \(2007\)](#)**

Think Local, Act Personal<sup>9</sup> builds on the landmark protocol Putting People First<sup>11</sup>, which sets out governmental commitment to independent living for all adults. Some of the key elements of personalised adult social care are that:

- All people, irrespective of illness or disability, should be supported to sustain a family unit, which avoids children being required to take on inappropriate caring roles.
- Family members and carers should be treated as experts and care partners.
- Carers should be supported by programmes which develop their skills and confidence.
- Systems should support integrated working with children's services, to include transition planning and parent carers, and identifying and addressing concerns about children's welfare.

Adult social care will also take responsibility for championing local action to tackle the stigma faced by people with mental health problems.

### [Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children](#)<sup>12</sup>

Concerns about risks to children are a strong driver to improve inter-agency communication, collaboration and integration. Updated from the 2006 original, the new version of Working Together reflects the growing importance of inter-agency collaboration and includes strengthened recommendations, such as the recommendation that adult mental health services sit on Local Safeguarding Children's Boards, which have the potential to benefit families affected by parental mental health.

### [New Horizons \(2009\)](#)

Now superseded by No Health Without Mental Health, New Horizons was a Labour administration strategy to promote good mental health and wellbeing, while improving services for people who have mental health problems. It aimed to build on the National Service Framework for Mental Health – widely acknowledged as the catalyst for improving mental health care – which came to an end in 2009.

New Horizons takes a new approach to whole-population mental health. The focus on prevention and maintaining good mental health, and on promoting recovery, is particularly relevant to parents with mental health problems and their children, as is putting mental health promotion at the centre of public health efforts. Many services, not normally considered as mental health services, can help promote public mental health and wellbeing and prevent future problems, both individually and across generations. It is these types of services that New Horizons and No Health Without Mental Health try to promote. Examples include:

- mother and toddler groups
- school health initiatives that promote self-respect or better relationships
- reading initiatives which improve literacy, social skills and self-esteem.

### [Sure Start](#)

The [Sure Start Programme](#) and the development of Children's Centres brought together early education, childcare, health, employment and family support services

under one service and by 2010, 3,500 such centres in England were scheduled. Originally targeted at the poorest families in England,<sup>13</sup> this is one of the most substantial social reform initiatives for families embarked upon in recent years. However, successive evaluations have had to acknowledge that greater effort is required to reach the most vulnerable households and in particular parents with mental health difficulties<sup>14</sup>.

### [Care Programme Approach \(CPA\) Briefing](#)<sup>15</sup>

This briefing summarises why it is important to address the needs of parents with mental health problems and ensure that they and their children receive support. It describes the potential of the CPA to improve outcomes for affected families. The CPA guidance recommends that the needs of the parent, the child and the family are assessed routinely at each stage of the care pathway from referral to review. Service activity data should be recorded, collected and used to inform local commissioning, reviewing eligibility criteria for access to assessment and services, as well as professional training and development. In addition, this briefing also references key related policy, guidelines, practice developments and further reading.

### [Refocusing the Care Programme Approach \(CPA\): Policy and Positive Practice Guidance](#)<sup>16</sup>

This report states that the needs of key groups, including parents, should be fully explored to make sure that the range of their needs are examined, understood and addressed when deciding their requirement for support under the new CPA. These were important changes to the CPA process which for the first time explicitly recognised the needs of the adult as a parent and the importance of taking a holistic approach to the assessment and care planning process.

### **Families at Risk Review 2007–2008<sup>17</sup> and Reaching out: Think Family 2008<sup>18</sup>**

These two reports from the Social Exclusion Unit (SEU) Task Force (SEU 2008a, 2008b) outline the previous government's commitment to ensuring that adult services support whole families, not just individuals.

In order to support and enable local services to put these principles into action, the previous government committed to:

- launching a series of Family Pathfinders to test and develop the Think Family model and to generate and share evidence of what works on the ground
- continuing to invest in projects such as Family Nurse Partnerships and FIPs with the aim of embedding early intervention and prevention within the existing system of support and extending tailored family services to reach a wider range of vulnerable families
- extending cooperation across children's services to include adult social services, so that all services share responsibility for family outcomes. The aim is to encourage and empower frontline staff to innovate and cooperate in response to whole family situations.

Much of this work, and the learning from it, is now feeding into the Troubled Families initiative.

In Wales, the updated 'National service framework for mental health'<sup>19</sup> published in 2005, committed the Welsh Assembly Government and local authorities/local health boards to implement local and national actions to promote social inclusion. Included within this were specific actions to meet the needs of parents who have mental health problems.

### **Mental Health and Social Exclusion report 2004<sup>20</sup>**

This report addressed the social and economic costs of mental health problems and their impact on family wellbeing and child development. Included in the report was a 27-point action plan to improve access to social participation, employment and services for those affected by mental health problems. Action 16 of the plan focused on enhancing opportunities and outcomes for parents with mental health needs and their children. [A review of the implementation of Action 16 can be found here](#)

### **Every Child Matters: Change for Children**

Every Child Matters: Change for Children<sup>21</sup> sets out the national framework to build services around the needs of children and young people so that we maximise opportunity and minimise risk of poor outcomes. The Children Act 2004 (which also covers Wales) provides the legislative foundation for whole-system reform. It outlines new statutory duties and clarifies accountabilities for children's services. It acknowledges that legislation by itself is not enough: it needs to be part of a wider process that can only be delivered through local leaders working together in strong partnership with local communities.

Every Child Matters identifies five outcomes that are key to wellbeing in childhood and later life:

1. being healthy
2. staying safe
3. enjoying and achieving
4. making a positive contribution
5. achieving economic wellbeing.

The aim is to improve those outcomes for all children and to narrow the gap in outcomes between those who do well and those who do not.

### **The policy context in Northern Ireland**

Health and social care policy in Northern Ireland is the remit of the Department of Health, Social Services and Public Safety (DHSSPS). Legislation and policies affecting parental mental health and child welfare therefore differ from those in the rest of the UK, although the acceptance of the need to work with the whole family is a common thread.

[Our Children and Young People – Our Pledge<sup>22</sup>](#) is a 10-year strategy for children and young people in Northern Ireland, similar to Every Child Matters, which seeks to ensure all children and young people:



- are healthy
- enjoy learning and achieving
- live in safety and with stability
- experience economic and environmental wellbeing
- contribute positively to community and society
- live in a society which respects their rights.

It identifies that not all children have an equal start in life and that targeted support should be available to particular groups to ensure that all young people have the opportunity to fulfil their potential. It proposes a whole-child approach to ensure support in each of these key areas.

### **Inspection of child protection services & subsequent standards 2006-2008**

[An inspection of child protection services in Northern Ireland](#)<sup>23</sup> found some gaps at the child protection and adult mental health interface and recommended: 'There is a need, at all levels, for more effective interagency strategies for responding to alcohol and drug misuse, mental health problems and domestic violence and their impact on children and young people.'

The subsequent [DHSSPS Standards for Child Protection Services](#)<sup>24</sup> referred to the need for effective arrangements to manage the interface between child protection and adult mental health services.

### **Impact of the [O'Neill inquiry](#) and others into service shortcomings**

In Northern Ireland, there have been a number of cases where children have died or been seriously injured, and inquires into the circumstances surrounding these cases identified parental mental health and deficits in communication and joint working between agencies as contributing factors. In 2005, Madeleine O'Neill, who was in receipt of mental health services, took the life of her nine-year-old daughter Lauren, and then killed herself. The Report of the Independent Inquiry Panel in 2007 found that communication between professionals in relation to hospital admissions and transfers, between consultant medical staff, between hospitals, and between professionals and relatives were potential weaknesses in the support offered to Madeleine and her daughter. The report also highlighted that staff failed to recognise the relationship between child protection and mental health.

A 2008 report into another major child protection case again brought into focus deficits in working relationships between mental health services and children's services, suggesting that the way in which these services work together needed to improve.

As a direct result of the O'Neill Inquiry, the DHSSPS funded two project managers to lead a three-year project to pilot the recommendations of SCIE's Guide 30, 'Think child, think parent, think family', as a way to improve across the children's services and mental health interface. This initiative also covered associated departments such as maternity services, A & E, allied health professional services, and

psychological therapies in promoting a Think Family culture across Northern Ireland health and social care provision.

SCIE's Guide 30 and A t a g lance 3 2 ha ve r eceived f ormal e ndorsement from DHSSPS.

### **Parenting strategy**

The [DHSSPS Families Matter strategy](#) (2009)<sup>25</sup> focuses on early intervention, prevention and universal support for families. The implementation of the strategy and supporting initiatives, in conjunction with Care Matters NI, should ensure that families' needs will be addressed across the spectrum of intervention - from universal need to crisis intervention - in order to support parents and address better outcomes for children and families. The strategy does recognise parents with mental health problems as a group who are prone to exclusion from health and social care provision.

### **[Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services](#)**<sup>26</sup>

This guidance describes the principles of best practice to assist individual mental health and learning disability care professionals, multidisciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that service users may pose to themselves or others, including the staff who care for them, their families, carers or the general public. It provides guidance on assessing risk to children and young people.

### **Mental health service framework and legislation**

The [Service Framework for Mental Health & Wellbeing](#) was launched in October 2011 . It makes significant references to SCIE's Think Family guide, and other SCIE resources, as the evidence base for many of the standards. The Framework also explicitly sets out how the family model should be taken into consideration when implementing the standards framework. The Northern Ireland Frameworks 'are unique in including measurable performance targets for each standard'<sup>27</sup>. The framework builds upon the 'Strategic framework for adult mental health services', which recognises parenting roles in a section on carers and contains a recommendation that 'service users who are parents should be supported in their parenting role'<sup>28</sup>

The existing legislation for mental health is the Mental Health (NI) Order 1986, which is outdated. A single piece of legislation covering mental health and mental capacity is under development and is being considered by the NI Assembly during 2011. It is due for implementation in 2012.

### **The organisational context**

Research has shown that adult mental health and children's services need to work together to be able to meet the needs of families. However, the current organisational context is very complex. Mental health and children's services each

have separate legal frameworks and therefore separate guidance on policy and practice. This has led to specialisation of knowledge and management structures within the different departments. Managers and practitioners have also reported that the lack of a family perspective in central policy directives or performance indicators has made it difficult to make progress in this area.

Specialisation in health and social care has had its benefits - for example the opportunity for in-depth training and experience in one area - but has also limited the breadth of view of the same professions.

There have been a number of national and local developments aiming to improve cross-organisational working, in response to research evidence and following consultation with people who use services. For example:

- Crossing Bridges – a ‘train the trainers’ programme<sup>29</sup>
- inter-agency service protocols and strategies
- recruitment of specialist interface workers
- services commissioned specifically to offer support to families where there is a parent with a mental health problem.

Working in both adult mental health and children’s social care services is particularly difficult. Both areas are highly emotive: they attract high levels of media attention and criticism, and staff can be wary of stepping outside professional boundaries.

Breaking down these professional barriers is as important as addressing the stigma that exists in accessing services for parents and children.

## Think Family as a concept, and its implications for practice

The Think Family agenda recognises and promotes the importance of a whole-family approach which is built on the principles of ‘Reaching out: think family’<sup>18</sup>:

- No wrong door – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children’s services.
- Looking at the whole family – services working with both adults and children take into account family circumstances and responsibilities. For example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children.
- Providing support tailored to need – working with families to agree a package of support best suited to their particular situation.
- Building on family strengths – practitioners work in partnership with families, recognising and promoting resilience, and helping them to build their capabilities. For example, family group conferencing is used to empower a family to negotiate their own solution to a problem.

A family focus alone may not be enough to address the problems faced by some parents with a mental health problem, nor will it necessarily prevent a child from suffering harm. The adults’ problems need to be addressed through specific clinical

expertise and services, just as children’s problems need to be, as well as offering a whole-family approach where appropriate.

While the recommendations in this guide wholeheartedly support a family focus, it should not be seen as an alternative to providing individual care but must be considered alongside it. This means thinking about the child, the parent and the family, with adult and children’s health and social care services working together to consider the needs of the individual in the context of their relationships and their environment. ‘Think parent, think child, think family’ is therefore the guiding principle for this guide.

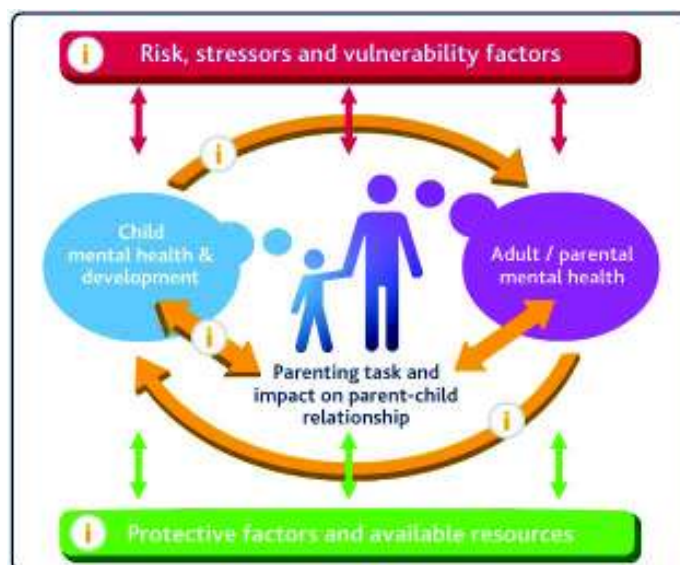
## The Family Model

The Crossing Bridges Family Model<sup>6</sup> is a useful conceptual framework that can help staff to consider the parent, the child and the family as a whole when assessing the needs of - and planning care packages for - families with a parent suffering from a mental health problem. The model illustrates how the mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked in at least three ways (see Figure 1):

- Parental mental health problems can adversely affect the development, and in some cases the safety, of children.
- Growing up with a mentally ill parent can have a negative impact on a person’s adjustment in adulthood, including their transition to parenthood.
- Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers.

The model also identifies that there are risks, stressors and vulnerability factors increasing the likelihood of a poor outcome, as well as strengths, resources and protective factors that enable families to overcome adversity.

**Figure 1** The Family Model



## **Risks, stressors and vulnerability factors**

Individual risk or stress factors, on their own, do not necessarily have a serious effect on an adult's parenting capacity or their children's mental health. However, some parents with mental health problems will face multiple adversities. Risk factors are also cumulative: the presence of more than one increases the likelihood that the problems experienced and impact on the child and parent will be more serious. It is when three or more environmental and/or personal factors occur in combination that a negative impact on child and/or parental mental health is much more likely. For example, the presence of drug or alcohol dependency and domestic violence, in addition to mental health problems with little or no family or community support, would indicate an increased likelihood of risk of harm to the child and to parents' mental health and wellbeing.

Risks can also change over time and create acute problems. For example, going into hospital can represent a significant crisis in terms of family life. Everyday routines are disrupted, other adults are overstretched, and both parents and children often feel worried and powerless. An effective intervention needs to consider the outcomes for the whole family.

Risks to health and wellbeing will also vary from person to person. For example, people with the same mental health problem can experience very different symptoms and behave in different ways. Therefore, relying on a diagnosis is not sufficient to assess levels of risk. This requires an assessment of every individual's level of impairment and the impact on the family.

## **Strengths, protective factors and resources**

The factors which can promote resilience in children – i.e. the factors which determine how well a child copes with their parent's mental health problem – are related to:

- their physical traits and personality
- their relationships with other family members
- the immediate environment in which they live
- life events.

People acquire whatever qualities of resilience they may have in two ways: by what they are born with through their genes, and by the effects of subsequent social experience. The surrounding environment and an individual's biological make-up will continually interact and influence each other in aiding or hindering a child's ability to cope with living with a parent who has a mental health problem.

## **Risk to resilience**

It may not be possible to easily change all the adversities which families experience. However, promoting and supporting protective factors can help reduce the negative effects when a parent is mentally ill.

For children, all protective strategies operate through one or more of the following processes<sup>30</sup>:

- by altering the child's perceptions of, or exposure to, risk of harm
- by reducing the cumulative effect of risk factors compounding each other
- by helping the child improve their self-esteem and self-efficacy
- by creating opportunities for change

In addition, there may be optimum situations or times to target specific interventions to boost resilience, for example, assistance with parental housing or financial problems or offering support at transition points in children's lives.

Promoting resilience does not mean minimising concerns about risk of poor outcomes. If a child is exposed to continuous and extreme stress, they are very unlikely to develop resilience. It is therefore unrealistic and unhelpful to rely exclusively on a resilience-led approach<sup>31</sup>.

### **Implications for organisations and for practice**

An approach based on the Family Model enables staff to:

- know what to look for
- take a holistic approach to assessment and consider the environment, family, cultural and social systems within which individuals live (e.g. housing, finance, employment, relationships)
- gain a better understanding of the links and relationships between the risk of poor outcomes and resilience; between adults and children; and between symptoms and parenting
- understand changing patterns over time, and what to do with the information they gather
- understand the risks to health and wellbeing that occur across generations and manage these risks to reduce their impact.

### **Implications for the frontline practitioner**

Adopting this approach requires a change in attitude and practice which includes:

- switching from a focus on diagnosis or pathology to concentrate on individual strengths and interventions that are strongly associated with promoting mental health and recovery, sustaining families and promoting inclusion
- raising the expectations of people who use mental health services who are parents and taking seriously their views of their resource needs
- looking at the family as a unit and focusing on positive interdependency and supportive relationships
- helping parents to understand their mental health problems, their treatment plan, and the potential impacts of mental health problems on their parenting, the parent-child relationship and the child
- working with parents and children to enable the child to have age-appropriate understanding of what is happening to their parent, information about what

services are available for them in their situation, and how they can access these.

At the same time, practitioners need to remain aware and be prepared to intervene when there is evidence that the child is suffering or is likely to suffer harm.

## Characteristics of a successful service

The characteristics or indicators of success outlined below are drawn from the requirements of law and policy, along with messages from research and practice. We have included this section as it gives an overview of what this guide is striving to achieve. It also provides broad outcome measures that can be used to assess impact locally and in evaluating the impact of the guidance overall.

A successful service will:

- promote resilience and the wellbeing of all family members now and in the future
- offer appropriate support to avoid crises and manage them appropriately should they arise
- secure child safety.

A high-quality service that incorporates a 'think individual, think family' model is one that:

- respects individuals' wishes and needs and their role and responsibilities in a family
- incorporates a 'strengths- and resilience-led' perspective, believing that change can be possible – even in unpromising conditions – and that it may start in simple ways
- intervenes early to avoid crises, stops them soon after they start and continues to provide support once the crisis has been resolved
- is built upon:
  - a thorough understanding of the developmental needs of children
  - the capacities of parents (or caregivers) to respond appropriately to these needs
  - the impact of wider family and environmental factors on parenting capacity
  - the combined impact of parental mental health problems and environmental factors on children
  - the impact of parenting on a parent's mental health
- incorporates a public health perspective to address the potential impact of parental mental health problems on the child over time and across generations
- supports the empowerment of people who use services through sharing information and knowledge and ensuring their involvement in all stages of the planning and delivery of their care

- respects the right of the child to maintain direct contact with both parents, except if this is contrary to the child’s best interests (and limited by a contact order).

To achieve this, a cross-agency response will need to<sup>32</sup>:

- draw upon an established knowledge base which integrates research evidence and practitioner and user expertise
- promote holistic assessment with a genuine focus on prevention and promoting the health and wellbeing of all family members
- include assessment and analysis of risk to health and wellbeing that investigates opportunities and obstacles for the present and the future
- ensure continued assessment of the impact of parental mental health on the family and if children are separated from their parents
- consider the timing and timeliness of interventions when prioritising services
- be flexible enough to deal with complexity and facilitate more cross-agency working for the benefit of parents and children
- strive to make services accessible, acceptable, effective, and accountable to parents with mental health problems and their children.

## 2 Improving access to services, screening and signposting

**The following practice examples link to this section:**

- Practice example 1 (NI Standardised Screening)
- Practice example 2 (Liverpool e-bulletin)
- Practice example 3 (NS champions’ group)
- Practice example 4 (NI monthly messages)

### Problems with current practice

Families with a parent with mental health problems often fall through the service net because:

- staff do not ask the right questions early on
- there are ambiguities with regard to the roles and responsibilities of different professionals
- there is a lack of signposting information – it is often the people who use services themselves who collect information and inform staff of other services and resources
- parents with a mental health problem may be reluctant to identify themselves because they fear losing parental responsibility for their children and because of the stigma associated with mental health and social services; children are also reluctant to raise concerns as they fear being separated from their family.



In a successful service:

- all families are routinely screened in adult services to identify which adults with mental health problems are also parents, and which parents in children's services have mental health problems
- given a parent's permission, staff make contact with all other relevant agencies to assess, plan and deliver a coordinated care package for the whole family
- families with a parent with a mental health problem are routinely signposted or referred to other appropriate services
- staff develop supportive relationships with adults who use services to allay people's fears and reduce the stigma surrounding services.

## Recommendations for change

Staff need to:

- Ask the right questions to identify families with a parent with a mental health problem. During the screening process, they should also explore the impact of any mental health problem on parenting and the child, and then put parents in touch with the right services. In children's services, staff will need effective ways of screening for and assessing parental mental health, including a tried and tested screening tool that identifies potential mental health problems. In adult services, staff will need to find out whether the adult is a parent or has childcare responsibilities and to record this. All staff may need training and support to understand why it is important to ask for this information and how to change their practice.
- Develop a working knowledge and confidence in how other services operate, what they have to offer and how to refer to them. Staff need to be able to reassure parents that services will meet their needs, provide written information about a service and, when necessary, be able to challenge other services and advocate on their behalf. This applies to staff in all settings. For example, enabling children's centres, schools, FIPs and GPs to navigate the local care pathway for mental health and children's services would provide a valuable mechanism to join up healthcare planning with family, parenting and children's services.
- Reassure parents that identifying a need for support is a way of *avoiding* rather than *precipitating* child protection measures.
- Involve parents and children as much as possible in the screening process, explaining that the process is important for making sure families get the support they need. This should be the start of developing a supportive and therapeutic relationship.
- Be proactive in developing good working relationships with their counterparts in other agencies, so as to facilitate joint working and shared case management.

Organisations need to:

- Develop new systems and tools in collaboration with parents and children (or customise existing ones) to routinely collect information about families where a parent has a mental health problem and record the data for future use. This information is essential for individual case assessment and care management. It is also crucial in building up a picture of the potential population for use by commissioners and managers of adult mental health and children's services.
- Provide training for their staff in talking with children, young people and adults to support the use of new screening tools as well as training to clarify roles and responsibilities in terms of collecting this information and acting on it. This applies to all staff in all agencies.
- Produce written and other formats of information about their services and include provision of translated materials and culturally sensitive information. This needs to include information about:
  - adult mental health problems and the range of treatment and support available
  - the connections between adult mental health problems and parenting, and what has been helpful for families
  - how agencies work together to support individuals and families
  - services for young carers, as well as general information for all carers that explains what a carer's assessment is and what support is available
  - clear signposting to other services, including those providing parenting support and parenting education, and relationship support
  - local and national advocacy services.
- Develop a communications strategy to tackle the stigma and fears that parents and children have about approaching and receiving services. It should be a priority to enable families to get the support they need as soon as possible and the focus should be on promoting good mental health and wellbeing for all family members. This strategy needs to span universal, targeted/specialist and secondary services and reach families at all levels of need. It is best coordinated by Children's Trusts working with local commissioners of adult mental health services.

Managers need to:

- Develop a 'whole family' perspective and along with all other staff improve their knowledge and understanding of the interrelated nature of mental health difficulties, parenting and child development, and reflect this learning in decision-making.
- Provide advice and guidance, both informally and through more formal systems, to help frontline staff work across agencies and signpost and refer families to appropriate services.

Use management information systems/case management data and staff supervision and appraisal to ensure that referral, assessment and screening take place, that staff

know how to use appropriate screening tools for adult mental health and are using them effectively. They also need to ensure that information-sharing is of high quality.

### 3 Assessment

**The following practice examples link to this section:**

Practice example 5 (Birmingham cross-checking)

Practice example 6 (NI – UNOCINI)

#### Problems with current practice

Many staff lack confidence in making an assessment of the impact of mental health problems on a family. Staff from children's services may have only a limited knowledge of mental health problems, particularly their impact on parenting. They may not consider that parenting also has an impact on a person's mental health. Adult mental health staff can provide valuable information in support of these assessments, but it is not their responsibility to make a final judgement.

Families facing multiple adversities (e.g. depression, drug and alcohol misuse, and homelessness) need careful multi-disciplinary and multi-agency assessment and support. People who use services have commented that assessments are only 'partial' because they are too fragmented and 'only the service user holds the whole picture'.

Assessments rarely explore a family's strengths in the same amount of detail as any areas of concern. The concept of resilience is not generally well understood. At the same time, some practitioners can be overly optimistic, and fail to recognise the need to protect children from harm. This has been a serious problem in some cases where children have died.

Assessments can be based on limited information is not shared appropriately across agencies:

- Different professional groups may not share the right information because they work to different criteria for information-sharing, use a different language and lack sufficient understanding of each others' roles. This means they may not understand what information is important for other agencies to have and so do not ask the right questions or pass the information on.
- Adult mental health staff are concerned that children's social care staff may make important decisions based on limited information such as a mental health diagnosis, or may over- or under react because they do not have a good understanding of mental health problems.
- Children's social care staff report that it is sometimes difficult to get reliable information from their adult mental health colleagues, particularly psychiatrists.

Criteria to access services currently act as a barrier to providing services to these families because:

- There are separate local criteria for adult and children's services which work against identifying the needs of the family as a whole.
- Criteria are set very high which can lead to some families falling through the service net.
- Local eligibility is based on weaknesses and problems. This means families must present themselves in ways which hide their strengths and resources and means they need to exaggerate their difficulties to get access to a service. This also makes it extremely difficult to identify and prioritise opportunities for early intervention and prevention.

In a successful service:

- The assessment takes account of the whole family's full range of needs – including those of young carers.
- The assessment takes account of present and future needs. For example, whether intervening in the present can help to avoid crises or prevent future ill health for any member of the family.
- The assessment considers what support can be provided to maintain family wellbeing.
- Local eligibility criteria for services take account of the complex and varied needs of the whole family.
- Staff quickly identify the most vulnerable families, and intervene to prevent a crisis. All assessments comment on the mental health of both parents and any other adult member of the household, and record whether the parents live together and the degree of contact with children.
- All staff are equipped to identify cases where children are suffering, or are likely to suffer, significant harm and are able to respond quickly and effectively.

## Recommendations for change

Staff need to:

- Take a systemic and socially inclusive approach to assessments. This is essential because parents often need advice on other matters such as housing and financial problems that would otherwise add stress and limit their chances of recovery.
- Involve all members of the family including the children in the process of assessment (as well as subsequent care planning and review). Staff may need to support children to be involved. They should also identify whether there is an adult or young person carrying out caring responsibilities in the family and where appropriate carry out a carer's assessment as soon as possible.
- Develop good working relationships with their counterparts in other agencies to support information-sharing and joint assessments. Staff need to gain a better understanding of other professionals' roles and their differing

perspectives. They need to feel confident enough to challenge other agencies where appropriate.

- Be very clear about what information can be shared and with whom, also seeking parents' and children's permission for information-sharing wherever possible.
- Be able to recognise the most vulnerable groups and know from where to access appropriate advice, including: young mothers, women in the perinatal period, fathers, black and minority ethnic families, asylum seekers, parents with dual diagnosis or personality disorder, parents experiencing domestic violence, families who are separated and looked-after children.
- Be better informed about what forms of adult mental health problems and their symptoms and associated behaviours could present a risk of harm to children. Staff also need to be aware of their responsibilities for safeguarding children (See Box 1).

### **Box 1 Safeguarding children in families with a parent with mental health problems**

The responsibility for safeguarding children does not only lie with children's services. It is a requirement of safeguarding children policy that adult services, including mental health services, know whether their service users have children or are in contact with children. This again highlights the importance of routinely identifying and recording which people who use mental health services are parents and which children have parents with mental health problems.

This is not to imply that adult mental health problems are the only serious risk factor for children's safety. The research evidence suggests that other factors (e.g. parental drug and alcohol misuse, domestic violence, and/or learning disability) are often present in serious child abuse or neglect situations. It is therefore important to be able to recognise and understand what contribution adult mental health problems make to an assessment of overall risk of harm to children.

The lessons from cases where children have been killed by their parents, or suffered significant harm, suggest it is also important to train and support for staff so that they are:

- constantly vigilant
- open and inquisitive, regardless of any assumptions based on previous assessments
- aware of the need to reassess following new or increasing numbers of incidents and following changes in circumstances
- able to challenge colleagues within partner agencies if required
- aware of their responsibility to pass on concerns about the welfare of a child to Children's Social Care.

Organisations need to:

- Adapt and develop existing assessment and recording processes to take account of the whole family.
- Provide staff with assessment tools (or amend existing tools) that identify the needs of parents, children, carers and young carers and take account of a family's strengths as well as their difficulties. These tools also need to be acceptable and accessible to families. They should be applied in universal, targeted and specialist, maternity and secondary care services.
- Develop information-sharing and joint working policies/protocols to improve communication, coordination and collaboration within their organisation and across agencies.
- Train and support their staff in making joint assessments. Training should include how to interpret the information gathered in assessment and support should include clear signposting to specialist consultation and advice for complex cases (e.g. child and family mental health, risk assessment and culturally sensitive services).
- Develop and implement 'family' threshold criteria for access to services to take into account the individual *and* combined needs of parents, carers and children. They also need to ensure that vulnerable families meet necessary service thresholds, to ensure better access to services regardless of setting and agency.
- Train all their staff to increase their knowledge and understanding of adult mental health problems and their impact on the family in the present, over time and across generations, to help them identify when to intervene early or as a preventive measure.
- Train and support their staff to recognise the signs of adult mental distress so that they are aware of the risk of neglect, abuse and domestic abuse and are equipped to follow the local safeguarding procedures laid down for their services within their area.

Managers need to:

- Increase their knowledge of all parts of the professional network.
- Develop strong working relationships across divisions, particularly at senior management level.
- Foster a culture of respect for staff in different disciplines.
- Agree and record strategies for the management of joint cases (case files) where the situation is complex or there is a risk of poor outcomes.
- Develop new or adapt existing management information tools to ensure the quality and timeliness of assessments as part of their day-to-day supervision of staff

## 4 Planning care

**The following practice examples link to this section:**

Practice example 7 (Liverpool YC pathway)

Practice example 8 (NS complex case discussions)

Practice example 9 (Liverpool CMHT pilot)

### Problems with current practice

Difficulties seem to arise in developing care plans when more than one agency is involved. This is because staff from different disciplines often adopt different views. For example, staff from adult mental health services may not acknowledge that there is a risk of harm to children. At the same time, children's services staff may not accept that change might be possible for the parent. As a result, any joint care plans may not realise the potential to promote the resilience of either the parent or the child. In the absence of any preventative measures and forward planning, families can end up 'drifting' until crisis point is reached.

It also seems that there is little coordination of the care plans for the individuals within a family. For example, young carers' assessments are not routinely fed into adults' care plans. Similarly, the views of young people are often not taken into account when making decisions about the care and support of adult family members.

In a successful service:

- Care planning takes a holistic approach to include appropriate care plans for each individual family member as well as the family as a whole.
- The care plan involves all members of the family in its development and implementation to ensure it is relevant, realistic and achievable.
- The care plan is flexible enough to meet the needs of the individuals and the family as a whole, and to be able to respond to changes in circumstances. Allocating an individual budget could provide this flexibility and give people who use services more choice.
- The care plan includes contingency and crisis preparation for both predictable and unforeseen situations. For example, a parent showing recognised signs and symptoms of becoming unwell, a parent being made redundant, or a young person needing stability at home to study for GCSEs. Respite care, agreeing who the child should contact if their parent becomes unwell and other support services can be planned for such events.

### Recommendations for change

When writing, sharing and coordinating adult and child care plans, staff should ensure that:

- The needs of the adult as a parent, and their child, are addressed separately and together.
- The care plan explains the rationale for each recommendation including the preferences of the individual family members.
- The care plan includes realistic and relevant targets and timescales to address the specific difficulties faced by each family member.
- It is clear to all family members what the plan intends to achieve and how progress will be measured, including progress with parents' and children's understanding of the mental health problem.
- There is a clear explanation of what will happen, in what order and why, as well as who will be responsible for each intervention.
- There are clear lines of communication between staff providing services and individual family members.
- Parents and children/young carers can recognise when to ask for help and who to ask.
- There are clear arrangements for child care should the parent not be able to care for their children at any time, for example, during hospital admission. These should be agreeable to parents.
- It is clear how the views of family members will be obtained and recorded during the implementation of the care plan and its review.

Staff need to develop care plans that aim to increase resilience. Research has shown that increasing every family member's understanding of a parent's mental health problem is highly successful in terms of increasing their ability to cope. Therefore, care plans need to provide details of how:

- Parents will be assisted in understanding their own mental health problems
- Children will be helped to understand their parent's mental health difficulties
- Any potential negative impacts of mental health problems on the family will be minimised
- Children will be protected from the risk of harm and supported to promote their continued development and wellbeing
- Communication will be improved between family members and relationships maintained
- Family health and wellbeing will be promoted and maintained.

Staff should consider whether using a personal budget or direct payment would give greater flexibility to the care package to better meet the needs of the individual and the family.

Contingency and crisis plans (may also be relevant to advance directives) should include how many children the parent has, their ages and gender, and the arrangements for their care to be put in place if the parent is not able to care for them at any time e.g. if a parent is admitted to hospital.



Organisations need to:

- Provide training and support to their staff to improve the effectiveness and functioning of interagency working. This will support the development of coordinated care plans.
- Develop interagency policies/protocols in collaboration with parents and children that include a performance management and evaluation framework to ensure their use in everyday practice.

Managers need to:

'Manage' and monitor the use of interagency policies/protocols and make them part of mainstream management and practice. They should consider adapting existing electronic case management and management information systems to include a requirement for staff to record that they have followed the protocol and that managers have observed that this has happened.

## 5 Providing care

**The following practice examples link to this section:**

Practice example 10 (NS/Liverpool/Southwark – embedding staff)

Practice example 11 (Southwark – toddler group)

### Problems with current practice

There are gaps between children's and adult services which do not reflect the extent to which children's and adults' needs are interlinked. There are few services that aim to support the whole family.

Parents and young people are not invited to participate in commissioning and service development initiatives in a meaningful way.

Professionals want to be able to work together to better meet the needs of a whole family. Strict entry criteria and service boundaries do not allow practitioners to collaborate or undertake joint working arrangements across service settings. There can also be disagreements as to where responsibilities lie. For example, adult mental health services tend not to arrange home support for children when a parent requires treatment, because children and family services are viewed as being responsible for all forms of child support.

There are also differences between the professionals' and parents' priorities for support. Professionals do not always prioritise more social interventions, but for parents, it may be more important to deal with any financial or housing problems first, as they are then better able to usefully engage with any therapeutic intervention.

When it comes to commissioning services, commissioners tend to focus on meeting the needs of individuals, rather than families. Services for families with a parent with a mental health problem are not being given a high priority because:

- the drivers for improving outcomes for these families are less significant in comparison with others
- there are no specific performance indicators to promote service provision in this area
- targets and standards for mental health are about assessing and treating individuals (this is in contrast to the recently published Service Framework for Mental Health in Northern Ireland, which refers to the SCIE guide and Think Family model as an important consideration)
- systems for joint commissioning across services exist, but are not yet being used fully.

There are also limitations on the kinds of service that can be developed because of current funding arrangements:

- There is little long-term funding for services, even though families often experience chronic problems and would benefit from longer-term, 'revolving door' support. In many instances this might be less costly than, for example, hospital stays and children being looked after by statutory services. There would also be enormous value in enabling families to re-engage with services they trust.
- There are problems with funding joint care packages. Disagreements between services are often about who will pay for which service component.

In a successful service:

- Parents and children are meaningfully involved in developing, reviewing and evaluating services (e.g. commissioning processes and developing interagency service protocols).
- The specific needs of families with parental mental health problems are met.
- The variety of needs experienced by members of these families are addressed.
- Staff take a greater account of parents' priorities and desired outcomes and their perceptions about the cause of their mental distress. They are more sensitive to the sometimes complicated, chaotic lives some of these families lead.
- Support is provided in the long term through long-term funding for services that have demonstrated continuous positive improvements for families.
- Barriers to access are addressed, including practical barriers (e.g. transport and childcare), as well as acceptability factors (e.g. sensitivity to ethnicity, sensitivity to parents' other needs and priorities).
- The most vulnerable and excluded groups are targeted by services (e.g. young mothers, mothers in the perinatal period, black and minority ethnic families, asylum seeking and refugee families, staff who use services, parents with personality disorder or dual diagnosis and their children, families who are separated temporarily or permanently).

- The emergence of mental health problems in the next generation is prevented by targeting children most at risk of poor outcomes, intervening early and using preventive interventions (e.g. supporting looked-after children to break the cycle of disadvantage that can pass across generations).

## Recommendations for change

All staff need to implement interventions that will:

- address immediate concerns about the safety of children
- quickly identify and treat any mental health problems
- help parents with mental health problems to better manage their symptoms
- prevent crises and promote good health and wellbeing
- help manage a crisis quickly and effectively
- prioritise social inclusion
- reflect the priorities of parents and their families
- be flexible enough to take account of issues such as medication side-effects, scheduling of hospital appointments etc.

Organisations need to:

- Develop, implement and regularly review interagency protocols that include clear pathways for decision-making, that are explicit about who makes decisions and in what circumstances, so that decisions are timely and delays in allocating services are avoided.
- Involve parents and young people in the development, review and evaluation of interagency protocols.
- Develop or maintain services that meet the full spectrum of need in these families including:
  - services that tackle social exclusion issues
  - family-focused mental health services
  - services for families whose problems are less severe, but who need help to maintain their health and wellbeing (e.g. including access to psychological therapies – IAPT)
  - interventions that will reduce other stresses on parents (e.g. short breaks for parents and shared care options)
  - services for young carers
  - services that help parents with parenting (e.g. childcare, parenting skills courses)
  - services that support parents through crises (e.g. when a parent goes into hospital).

- Develop commissioning processes to enable:
  - parents and children to be involved
  - joint commissioning across agencies
  - the development of non-traditional and creative ways of delivering services (e.g. delivering therapy services from libraries, community centres and children centres) as a means of targeting families and improving access
  - commissioning based on reliable information about how well services are meeting local needs
  - ongoing monitoring and evaluation to inform future planning and commissioning cycles.
  
- Change funding mechanisms to:
  - pool budgets so that adult mental health and children's services jointly fund these services, which will require developing new protocols that explicitly define who, how, why and when financial issues will be decided when agreeing multi-agency care packages
  - provide long-term funding (e.g. for voluntary sector services), so that they can continue to support families where a parent has a chronic mental health problem
  - make funds available for evaluating services, separate from the service delivery budget
  - facilitate the use of personal budgets and direct payments to give more flexibility and choice for parents.

## 6 Reviewing care plans

**The following practice examples link to this section:**

Practice example 12 (Lewisham YC involvement)

### Problems with current practice

Children and young people are not often involved in care planning and review. However, they need to be directly involved because they are direct beneficiaries of the care package, and also key to implementation plans.

In a successful service:

- Long-term assessments, involving continuous monitoring and review, enable services to respond to changes in family circumstances.
- Parents with mental health problems develop continuous, responsive relationships with trusted professionals, so that they and their children feel empowered to discuss any difficulties without feeling that they are being judged.

- Staff (inpatient nurses, community mental health staff, children's social care staff, foster carers etc.) work with families to make sure arrangements for the children's care, including any 'contact' arrangements, are put in place when a parent is hospitalised and that support is in place for the parent and child on discharge.
- Carers and young carers are involved in the care plan review for the person they care for.

## Recommendations for change

Staff need to:

- Seek parents' permission and as far as possible involve children and young carers in the parent's care plan review process. This is important because young people can provide a valuable and unique perspective on what has been happening with their parent, how it is has been for them and what they think has worked well. They can then also comment on how any changes in the care plan might affect them.
- Aim to review the carer's plan as close as possible to the review of the adult's care plan. This will ensure the care plans work better together and reflect both individual and family goals. It will also ensure that any changes to the care plan that affect the carer are also addressed in their own care plan.
- Ensure care plan reviews consider change in family circumstances over time. For example, if important life events such as the birth of another child, a child studying for GCSEs, or the six-week summer holidays are coming up, then this needs to be explored and any contingency or extra support included in the plans if necessary.

In terms of hospital admission and reviewing care, staff need to:

- Ensure that the care plans for the parent and child are reviewed when a parent is hospitalised or receiving respite and again before they are discharged.
- Prioritise and address any financial and housing issues arising from hospitalisation (e.g. interruptions in welfare benefits, assistance with child care to avoid a parent or carer having to take unpaid leave to look after the children during this time).
- Contact or help parents to contact their children's school to make them aware of the temporary changes in the family to maintain family life during a time of crisis and ease the path of return when the parent returns home.
- On discharge from hospital or during periods of 'hospital leave' ensure that enough time is given to put any identified support in place for the parent and child as 'coming back together' for families can be a very stressful time with high expectations.

If children and families or other essential support services are involved in the parent and children's care then it is imperative that the doctor and ward staff in charge of the parent's inpatient care involve named agencies in discharging planning or give adequate notice of discharge arrangements.

## 7 Strategic approach

**The following practice examples link to this section:**

Practice example 13 (Lewisham protocol)  
Practice example 14 (Southwark advice & liaison)  
Practice example 15 (Three WFD briefs: Birmingham – Meriden training; Liverpool – lunchtime learning; NS – SCR training through drama)  
Practice example 16 (Southwark FPM training)  
Practice example 17 (NI Knowledge & Competency framework)

### Multi-agency review

Implementing these recommendations requires more interagency working, joined-up services and pooling of resources. We therefore recommend conducting a multi-agency, strategic review that involves:

- Mapping the services currently available across all sectors to parents with mental health problems and their children, and identifying how well the services meet these families' needs across the full spectrum of problems.
- Working in partnership with parents and children at all levels and at all stages to ensure a service user centred approach to developing and delivering services that reflects what families say they want. Involving parents and children will lead to better service outcomes.
- Generating clear family-focused outcome measures, management targets, accountability measures and agreed audit and evaluation plans to monitor and evaluate the implementation of the strategy.
- Commissioners of adult mental health and children's services are well placed to initiate, manage, monitor and report on the development and implementation of a strategy. They will need to take the lead in coordinating and managing change.

### Senior-level commitment

There needs to be support from the top of organisations so that these changes become a 'must do' rather than an optional extra. Staff have found that the absence of a 'must do' incentive or lever centrally and locally has contributed to the difficulties in mainstreaming family-focused protocols.

Specific organisation or management targets are also necessary for these changes to become a priority for mainstream practice. Embedding the changes in culture and practice requires strong leadership and high-quality management.

Managers and supervisors have a responsibility to ensure that the changes happen in practice by:

- supporting staff
- identifying what is needed to promote change
- recording the changes that happen
- ensuring their staff are accountable for delivering change
- monitoring the quality and impact of changes.

We therefore recommend that:

- a 'think family strategy' is developed for leaders and managers, to engage them in taking forward the recommendations for change
- local 'champions' are identified with specific responsibility for ensuring that recommendations are implemented
- training managers are charged with delivering the training programmes necessary to support all staff – frontline practitioners and senior-level managers.

## Workforce development

Frontline managers and supervisors in all services are in a unique and important position to develop and lead practice change within and across services, but investment is needed in training and staff development before these roles can be used to their best advantage. There appears to be a need for training, particularly joint training, in this area.

We therefore recommend that in terms of professional qualifications, those responsible for professional education and training and workforce standards should introduce a family perspective.

In terms of continuing professional development we recommend that:

- For social workers (adult and child), accredited post-qualifying standards and courses should include specific material about how to deal with complexity, think child, think parent and think family, and how to work across service interfaces to promote the social inclusion and health and wellbeing of individuals and families. This is best delivered after a year or more in practice.
- Joint training is provided for staff in adult mental health and children's services or for other professional groups (e.g. primary and secondary care staff), as this can help to break down barriers and increases people's understanding of other service areas and responsibilities.
- A new leadership programme for adult and children's social work supervisors and managers should be developed. This should help managers to support staff who are working across agencies and dealing with complex cases.

## 8 Putting it into practice

**The following practice examples link to this section:**

Practice example 18 (Liverpool/Southwark steering groups)

Practice example 19 (Lewisham user group)

Practice example 20 (Quick wins/embedding)

Practice example 21 (Southwark Parents' forum & film)

### Background to the implementation

To get away from producing another set of recommendations in this area without putting them to the test, SCIE decided to support the implementation of the original 'Think child, think parent, think family' guide in five English local authority areas, and all five of the Health and Social Care Trusts in Northern Ireland. From September 2009 – September 2011 in the English sites, and from September 2009 – March 2012 in Northern Ireland, practice development managers from SCIE supported the sites to develop whole-family working along the lines of the guide's key recommendations. The work has been evaluated by a SCIE research analyst, and the learning has been captured in the interim evaluation report (SCIE report 44) and the final evaluation report

In Northern Ireland, two full-time project managers ran the project, supported by an administrator. The project was overseen by a regional steering group, and local implementation was carried out by five Project Locality Teams. Work in each of the English sites was led by a project steering group, including representatives from adult mental health and children's social care services. The groups also often had representatives from the voluntary sector, child and adolescent mental health services and young carers' services.

In the English sites, implementation activities focused on:

- awareness raising and consultation via staff and service user consultation events, newsletter and e-bulletins, lunchtime learning sessions and staff briefings
- making strategic links with other initiatives such as Hidden Harm and young carers strategies
- workforce development and training, for example by including Think Family in existing induction and safeguarding training
- reviewing current working practices to assess compliance with the guide
- changes to care pathways, for example amending the young carers' Care Pathway to integrate it with the Common Assessment Framework process.

In Northern Ireland, the project managers undertook a number of regional pieces of work, including a multidisciplinary working agreement between adult mental health, children's and drug and alcohol services, and a knowledge and skills framework. They developed a set of outcomes and performance measures for the project and



collected service user views on a large scale using an online tool called Sensemaker.

The English sites each received £10,000 from the Department of Health to assist with implementation. It was used to fund things like:

- project manager/administrator support
- service user involvement activities
- the development and circulation of communication materials
- venues and refreshments for stakeholder events.

The work in Northern Ireland did not have a budget additional to that for the project managers and administrator. The implementation project took place at a time of budget cuts and restructuring in many public services. The ring-fencing of governmental Think Family funding was ended in this period, and key funding streams to support people with mental health problems, such as parenting programmes and Public Service Agreement (PSA) 16 funds, were reduced or stopped.

## The implementation plans

The key task for all of the implementation groups as they got together was to decide which of the guide's recommendations to focus on, and to formulate an implementation plan accordingly.

The English sites chose to work on different recommendations depending on local needs. However, all the sites planned to work on the recommendations relating to:

- taking a strategic approach
- communications
- screening and assessment
- workforce development.

In Northern Ireland, implementation proceeded sequentially through the nine priority recommendations.

As sites developed their plans, it became clear that whole-family approaches can apply to a range of services and service users. The sites worked across this range, with the majority of activities aimed at what we have termed 'families in need' – families who are known to statutory services, but are not at the highest tiers of either adult mental health or children's services.

While the sites aimed to implement the recommendations in the guide, the activities undertaken did not always correspond directly with one of the recommendations. Some activities applied to more than one recommendation. An inter-agency protocol setting out working arrangements between adult mental health and children's services, for example, may cover screening, assessment, planning and review. Other activities were not explicitly recommended in the guide, but were clearly in tune with its broader objectives. For example, placing mental health family support

workers in children's centres is not mentioned in the guide, but clearly supports a number of recommendations, such as the recommendation to develop services to support the full spectrum of need, including early intervention.

## What the sites did: England

The key areas focused on in the English sites can be grouped into a number of broad categories.

### Awareness raising

All sites worked to raise awareness of the 'Think child, think parent, think family' agenda and project among the wider staff group and among management. They did so in a variety of ways:

- A monthly ebulletin to all staff. [See practice example 2](#) The ebulletin had a distinctive Think Family branding and was compiled by a local authority communications officer who sat on the project steering group. The ebulletin was recognised as being extremely good, and won the Association of Social Care Communicators Award
- a dedicated web page about the project
- consultation and awareness-raising events with frontline staff, managers and service users. The aim was to inform people about the project, raise awareness of whole-family approaches, and to consult on the content of implementation plans
- a series of lunchtime learning sessions [See practice example 15](#)
- presentations at Local Safeguarding Children's Boards and other relevant meetings
- a Think Family conference, covering a number of strands of work (for example, parental mental health, substance misuse etc.)
- liaison with key staff groups such as those working in statutory children's services or community mental health teams. The purpose of this was to promote working practices that support whole-family working, for example completing Child in Need risk screens. In some sites, members of staff, such as safeguarding leads, routinely did this as part of their job. [See practice example 14](#)

### Making strategic links

The English sites in particular worked to link the implementation of the guide to other policies, such as:

- Children and Young People's Plans
- Parenting Strategies
- Young Carers' Strategies
- The Hidden Harm agenda, for example by having the Hidden Harm Coordinator on the project steering group
- wider Think Family agendas, covering learning disability, offenders, drug and alcohol misuse and domestic violence. [See practice example 20.](#)

The steering groups in the sites also made contact with other similar initiatives in their areas such as Family Improvement Partnerships.

### **Workforce development**

Many sites took specific actions to develop staff knowledge and skills. These were more in-depth than the awareness-raising activities listed above, providing a theoretical basis for whole-family working, and how this may affect their practice. Some sites amended existing training opportunities, such as staff inductions or safeguarding training, to ensure that they included Think Family principles.

The sites also commissioned additional training activities. One site ran a theatre-based training session for around 100 staff from various agencies about the principles of ‘Think child, think parent, think family’ [see practice example 15](#). Scenarios illustrating some of the challenges involved in working with families affected by parental mental ill health were dramatised by a professional theatre group, forming the basis of the training and discussion. In another site, Community Mental Health Team (CMHT) staff were given training using the Family Partnership Model [see practice example 16](#). A third site commissioned a local voluntary organisation to provide introductory Think Family training. [See practice example 15](#).

### **Working with families**

Direct family work was relatively infrequent, but was developed in some sites. A therapeutic family play group ran in one site [see practice example 11](#). In others, family therapists worked in children’s centres. [See practice example 10](#)

### **Reviewing current tools and ways of working**

A number of sites reviewed their existing ways of working to assess the extent to which they complied with the guide and to see what changes needed to be made. This included:

- reviewing existing joint working protocols between adult mental health and children’s services [see practice example 13](#)
- reviewing screening and assessment tools, such as the Child in Need risk screen
- revisions to the Care Pathway for young carers [see practice example 7](#)
- developing practitioner ‘champion’ groups to promote shared professional understanding and joint working with families [see practice example 3](#)
- the introduction of family mental health workers to children’s centres [see practice example 10](#)
- identifying trigger levels at which to make contact with other services [see practice example 5](#)
- developing the use of the pre-CAF as a way into children’s services [see practice example 9](#)
- establishing a forum for professionals to come together to discuss complex family cases [see practice example 8](#)
- seeking to alter working practices to promote young carer involvement in their parents’ care planning. [See practice example 12](#).

## What the sites did: Northern Ireland

In Northern Ireland, the project managers aimed to work sequentially through the priority recommendations in the guide. We capture some of the work here:

### Signposting and improving access to services

There were a number of activities as part of the work on this recommendation.

#### **Communication** See [practice example 4](#).

Things done to communicate the project and raise awareness internally included:

- a letter endorsing the implementation of the guide from the Department of Health, Social Services and Personal Safety (DHSSPS) to senior managers of the Trusts, outlining the importance of the work, and the need for it to be embedded within Trusts
- a quarterly newsletter sent to Health and Social Care Trust staff and other key stakeholders
- monthly good news stories.

### Multi-disciplinary regional agreement

A regional joint agreement was developed, setting out how staff in statutory and non-statutory organisations should respond to families with mental health and/or substance misuse problems. It articulated the actions that should be taken by staff who work primarily with adults and those who work primarily with children.

#### **Consultation with service users and carers**

As part of the activities on this work stream, the project managers in Northern Ireland worked with a local consultant to conduct a family experience survey to gain an understanding of families' and staff's experiences of the impact of parental mental health.

### Screening and assessment

#### **Reviewing multi-agency forms**

The project focused on reviewing existing screening and assessment tools to assess the extent to which they supported whole-family working. While SCIE always envisaged that the Think Family model could be applied to a wide range of services, the approach in Northern Ireland has involved an even broader range than originally anticipated, and wider than in the English sites. The Northern Ireland sites frequently included acute medical services and acute mental health services, and with the aim of trying to develop a shared 'form of words' See [practice example 1](#) across agencies working with families, services shared their screening and assessment forms. Some services were able to provide examples of good practice. For example, in one Project Locality Team area it was found that addiction services had particularly good screening and referral forms. These were then used as the template for other documentation.

### Changes to Understanding the Needs of Children in Northern Ireland (UNOCINI)

In Northern Ireland, all referrals to statutory children's services are made using the UNOCINI assessment form. One of the project managers was part of a working group to amend the guidance supporting the form so that it addressed Think Family

issues, including mental health and substance misuse. The revised guidance then went out for consultation with staff. [See practice example 6.](#)

### **Development of outcome/performance measures**

The project managers worked with Health and Social Care Board performance staff, to develop a set of outcome/performance measures for the project. Initial scoping work showed that there were very few existing performance indicators that could be used to promote whole-family working. The indicators developed therefore relied on primary data collection using surveys and case file audits. At the time of writing, a set of draft practice measures had been developed, including surveys of:

- staff's awareness of the Think Family model, and ways in which their practice is changing to support it
- initial screening, referral and assessment processes to ensure they reflect a family model approach
- evidence of shared care planning between mental health and children's services.

### **Making links with other initiatives**

The project managers worked to link the project to other relevant services and organisations. They met quarterly with directors of children's services, adult mental health services, acute hospital and nursing services. They also established working links with other relevant organisations, such as:

- Safety Improvement Forum – a forum helping health and social care organisations to implement evidence-based interventions known to save lives and reduce harm
- Bamford Task Force – the task force implementing the recommendations for modernisation of mental health services developed by the [Bamford Review](#)
- Regional Maternity Mental Health Forum
- Regional Implementation Team – the team leading a comprehensive change agenda for child protection services in Northern Ireland
- Hidden Harm Regional Quality Assurance Group
- The Regulation and Quality Improvement Authority
- Nursing/Allied Health Professionals, Medical and Social Work leads at DHSSPS.

The focus of these links was to prevent duplication of effort and to support relevant areas of work that chimed with the project's objectives. The link with the Hidden Harm work (which focuses on people with substance misuse problems) was particularly important: both the knowledge and skills framework and regional multidisciplinary agreement cover Hidden Harm client groups as well as parents with mental health problems and their families.

### **Work with the voluntary sector**

From the start, the voluntary sector was involved in the implementation of the Think Family approach in Northern Ireland, and there were voluntary sector representatives on each of the Project Locality Teams. In support of the approach,

voluntary sector organisations changed referral and assessment forms to enable the collection of relevant family information, such as:

- family composition, for example, name, relationship, age/date of birth, occupation/school/nursery
- impact of parents'/carers' mental health upon children of the family
- is there a child/young person undertaking caring?

The project highlighted that the voluntary sector workforce is not always appropriately skilled or qualified to undertake the screening and assessment required to support whole-family working approach, and that extra support and training is therefore needed.

### Knowledge and skills framework

The project managers, in consultation with relevant stakeholders, developed a knowledge and skills framework for whole-family working. [See practice example 17.](#) This sets out the skills and competences needed by health and social care professionals working with parents with mental health problems and their families. Its aim is to inform the commissioning and delivery of training for those working across adult mental health and children's services.

The project managers also made links with education representatives for social services, mental health, nursing and medicine, both at under- and post-graduate level, to raise awareness about the project and to discuss ways of including Think Family in higher and professional education.

### Lessons about process

When setting up the implementation project, SCIE envisaged a relatively linear process, in which sites would develop plans (including outcome measures), implement those plans, and then review progress and outcomes. Although we hoped the plans would ideally be living documents, which would change over time, it was nevertheless anticipated that the planning process would be the main driver of activity.

The sites in Northern Ireland to some extent followed this model and worked to a detailed regional plan. They were able to develop several strategic documents which have regional coverage. However, in the English sites and, to a lesser extent the Northern Irish sites too, the process of implementation was more 'organic' than expected. This showed itself in a number of ways:

- Rather than implementing and rolling out a specific number of new, pre-planned activities, sites started to embed a Think Family approach in existing documents and ways of working. This was in part a response to the busy environment in which people were working on numerous other responsibilities in addition to the guide. This left limited time for undertaking substantial stand-alone projects.
- It was also an explicit strategy for achieving impact. For an initiative to be successful it needs to work, and to be seen to work, in unison with other

similar initiatives. Embedding Think Family in a number of policies and initiatives may help to ensure its longevity during a time of change: even if one policy or initiative is discontinued, others will continue. [See practice example 20](#). This is known in the study of user involvement as ‘riddling the system’<sup>33</sup>.

- The sites responded to opportunities and changes in the practice and policy environment. For example, one site incorporated Think Family into a new structure for children’s services. Others took the opportunity to include Think Family as part of general reform processes, for example, the Reform Implementation Team and the Bamford Task Force in Northern Ireland. Others hope to exploit the constraints and restructuring affecting the sector to promote the early intervention and efficient working patterns inherent in whole-family approaches.

There were significant differences in the way that the guide was implemented in the English compared to the Northern Irish sites. This was largely due to the regional mandate for this work in Northern Ireland, supported by two full-time project managers. This meant that, for example, in Northern Ireland more time could be spent producing strategic, regional-level documents – such as a knowledge and skills framework and regional multi-disciplinary working agreement – than was possible in most of the English sites.

The Northern Ireland project also had the capacity and mandate to engage in other strategic-level activities, such as liaising with the regulators and providers of professional education, and meeting on an ongoing basis with government departments and non-departmental public bodies to share information and coordinate activities. SCIE undertook this role to some extent on behalf of the English sites, meeting regularly with the Department of Health and Department for Education.

## What helps and hinders progress

Throughout the implementation process, the sites and their SCIE supporters reflected on factors that helped and hindered progress in their area. Key factors were:

### Competing pressures and organisational change

Most people involved in this project had many other work responsibilities. While they found ways to manage this (including the ‘organic’ approach described above) it was a challenge to find the time and space for this project amid the many other demands they faced. Unsurprisingly then, people in the sites reported that competing priorities were a barrier to making progress with this work. This was not a reflection on their commitment or dedication, but rather an acknowledgement of the large portfolio of responsibilities that most professionals in health and social care have.

In addition, a number of sites went through organisational changes, such as restructuring of either local authority or NHS Trust services (or of both), changes to senior management, and proposed mergers of services. Sites were creative in making use of opportunities presented by this, but it also had some negative impact. For example, in some English sites, members of the project steering groups left due

to increased work pressures, or because of having to change role or return from secondments.

### **Sign-up from senior managers**

A key factor that repeatedly emerged was the need for senior members of staff (for example, assistant directors and directors) to sign up to this work. [See practice example 18](#). Their backing was key to a range of other factors such as:

- awareness of the project across the organisation
- leading the work at a senior level
- facilitating relationships within and across organisations
- ensuring that links were made to other initiatives
- the effectiveness of inter-agency working
- ensuring that staff were released for training, and generally able to prioritise this work.

### **Need for culture change**

Steering group members reported that the progress they had made would be furthered by a fuller change to organisational cultures and people's perception of what is within their professional remit. There were concerns that people may be even less willing to work outside what they see as their remit at a time of budget cuts and reorganisations.

It was felt that senior members of staff need to lead by example by modelling multi-agency working and flexible approaches.

### **Time to build relationships**

The extent to which true multi-agency working existed in the sites was unsurprisingly an important factor in determining progress. In sites with a history of working across agencies, key relationships were already in place, which helped people move forward. Elsewhere, it was clear that at least some members of project steering groups were meeting for the first time. This meant that in early meetings time was spent getting to know each other, learning about each other's roles and remits, and building relationships and trust. This is not unusual in multi-agency working. It did, however, reinforce the premise on which this work is built: that adult mental health and children's services do not always work closely together. It also highlighted the fact that even relatively senior members of staff (many steering group members are heads of service) in different agencies may not know each other.

Some groups of staff remained difficult to engage throughout the implementation project. In particular, engaging with schools and GPs proved challenging, in part due to the difficulties that school staff and GPs have in attending meetings during working hours. Sites also noted that the further services are away from the adult mental health/children's service interface, the harder they have been, perhaps unsurprisingly, to engage in this work.



## Resources

While some sites cited a lack of financial resources as a barrier to implementing the work, in others it seemed that the main difficulties could not easily be solved by injecting more cash into the service. This applied particularly to issues such as the lack of knowledge and understanding of other professionals' roles. This would seem to support our assertion that changing systems need not require substantial expenditure. However, it does mean that other things are required, such as effective collaboration and a conducive set of organisational cultures.

However, the broader financial climate has had an increasingly negative impact as the project has progressed. In Northern Ireland, efficiency savings in local services threatened to impede their ability to implement this agenda. Similarly, in the English sites, cuts to services began to take effect by the end of the first year of the implementation, thus reducing the capacity for putting whole-family approaches into practice. For example, one site built some of their plans on using the PSA 16 grant, and cuts to it were a real impediment to progress.

More fundamentally, reductions to budgets in many sites led to job losses, which meant those remaining in post had even greater workloads to manage. This had a clear impact on their ability to devote time to practice improvement work such as this project.

## Administrative and project management support

Having the support of an administrator and/or project manager was a key facilitator of progress in many sites. Administrators helped to provide practical support, such as taking and distributing minutes and agendas for meetings. They also acted as lynchpins for the steering groups, providing a single point of contact and continuity between meetings. In the sites which had project managers, this also helped to drive progress and ensure that tasks were accomplished.

## Involving users

Having service users - or their representatives - on steering groups, tended to add a dynamism to those groups, and a reality check when professionals became too involved in procedural concerns. [See practice examples 18 and 21](#). Hearing the experiences of parents and young carers could provide an important reminder to groups about the relevance of what they were trying to achieve. User forums provided a valuable space for parents to meet, and to share their ideas with the wider strategic body. [See practice examples 19 and 21](#).

## Lessons about practice – promising ideas

There were a number of approaches in the sites that seem to be promising in embedding whole-family working in adult mental health and children's services.

### Quick wins See practice example 20.

A number of sites undertook relatively quick and low-cost actions, which helped start the process of change. These included:

- lunchtime learning sessions
- ensuring that Think Family is included in staff inductions and safeguarding training
- liaison with key staff teams to ensure that practice is supporting a Think Family approach, for example, that Child in Need risk screens are being completed.

These types of action were helpful in raising staff awareness at an early stage of the project. This gave the work a sense of progress and achievement from the start.

### Linking with related initiatives See practice example 20.

This work is closely linked to a number of other agendas relating to vulnerable adults, parenting, and young carers including:

- **Hidden Harm** – Hidden Harm strategies are local responses to the Advisory Council on the Misuse of Drugs report on the impact on children of problematic drug use by parents. Links were made to this in Northern Ireland and two of the English sites.
- **Parenting** – There were clear links between this work and local parenting strategies. Some the potential benefits here were threatened following cuts to funding for parenting support.
- **Vulnerable adults (PSA16)** – This Public Service Agreement aimed to support vulnerable adults, including those with mental health problems, and therefore had links to this work. Again, however, the funding associated with this initiative has been cut.
- **Young carers** – The practice guidance to the Carers (Equal Opportunities) Act 2004 states that local authorities should have 'a protocol, shared between adults' and children's services, for identifying and assessing young carers.' A number of the implementation sites made links to their young carers' strategies.
- In Northern Ireland, the **reform of child protection services** led by the Reform Implementation Team has also been an important link.

Ensuring that links were made to these initiatives was an important way of sustaining the Think Family agenda after the period of implementation support from SCIE. It also promised to reduce duplicated efforts at a time of reduced resources.

### Building capacity in the voluntary and community sector

In many of the sites, the voluntary sector provides numerous services to parents with mental health problems and their families. However, the work in Northern Ireland in particular has shown that while this sector provides a valued and trusted service,

their systems and processes were not always conducive to effective screening, assessment and onward referral of parents with mental health problems.

Work was started in the region to improve and standardise referral forms and processes, and it appeared that the project improved the capacity of the sector to contribute to a Think Family approach to parental mental health.

Support for voluntary organisations to undertake their safeguarding and screening/signposting roles as effectively as possible was therefore a promising area of practice, particularly given the increased role that the voluntary sector is likely to play in future service delivery. Voluntary organisations need to communicate effectively with each other where more than one organisation is involved with the same family. Statutory services also need to ensure that voluntary and community organisations are well integrated into multi-agency processes to share information and co-ordinate services.

### **Practitioner champions** See practice example 3

Learning from the sites suggests that the practitioner champions model was a promising way of improving frontline practitioner knowledge and relationships. One site set up a practitioner champions group and the benefits of this group included:

- networking and forming relationships
- learning about the basics of each other's roles
- clarifying terminology
- highlighting systemic issues to feedback to the project steering group and senior managers.

The progress of the champions group led to the model being introduced in another English site, and Northern Ireland also designate staff as Think Family champions. It was notable, however, that once the champions group had developed a greater awareness about the issues involved in whole-family working, they then found the systems they used, such as assessment forms and practices, unsupportive of their increased enthusiasm for collaborative approaches. This tended to reinforce the sense that senior support is vital so that systems can be altered.

### **Building on the Common Assessment Framework (CAF) and Team Around the Child (TAC) processes**

Both the CAF and TAC processes can form a useful basis for a Think Family approach. The CAF is an assessment process for young people with needs which do not meet the criteria for statutory services (Tier 2). The CAF is intended to be a holistic assessment of a young person's circumstances and needs and, in many areas of the country, is used as the main way of referring a young person for support. Some of the sites identified the potential of the CAF to support whole-family working by encouraging practitioners in adult services to complete CAFs, and by encouraging all practitioners to take a holistic view of the whole family (not just the child) when completing the CAF.

TAC is a process for supporting a child who has additional needs. All the professionals involved with the child meet on a regular basis to plan and coordinate their care. One person is usually nominated the Lead Professional. A similar process is the Team Around the School, in which multi-agency groups of professionals meet to discuss children from particular schools who are raising concerns. Several of the English sites sought to expand the Team Around the Child/School to a Team Around the Family, with professionals who work with the parent also attending.

## Learning about practice – problem areas

The implementation project also provided useful learning about some difficult and intractable practice issues. The sites' experience demonstrated that, despite considerable effort, there are a number of issues that remain very difficult to surmount.

### Forming an accurate picture of the service user population

A number of the implementation sites attempted to find information about the service user population including:

- How many adults using mental health services have children
- How many children of parents using mental health services are on child protection plans or are children in need.

However, the sites usually found that they were unable to obtain this information, for two reasons:

- Features of individual electronic recording systems – for example, recording information about children on adult mental health electronic records is not done in a way that allows the extraction of data on numbers of service users with children.
- Lack of compatibility between electronic recording systems – cross-referencing children and parents across adult mental health and children's recording systems is challenging as systems typically use different unique reference numbers (NHS number for mental health, other numbering systems for children's services).

### Sharing information about individual cases

The incompatibility of IT systems also has an impact on individual casework as staff are not easily able to check which other services are involved with a particular family. This can mean that relevant information is not shared between professionals.

Quite apart from the IT issues, feedback from the sites – and in particular the practitioner champions groups – suggested that many frontline practitioners are still unsure as to when it is appropriate or inappropriate to share data. It appears that many practitioners tend to err on the side of caution and not share information.

### Thresholds

One of the recommendations in the guide is that local services should develop 'family thresholds' – thresholds for accessing services that take into account the needs of the whole family. The issue of thresholds remained a challenge throughout the implementation, although one of the sites began exploring options for how to

remedy this. However, it was apparent that one of the impacts of funding cuts may be to raise thresholds even higher.

### **Involving GPs and schools**

GPs and schools were not fully engaged in the project, in either the English or the Northern Irish sites. There are practical barriers to both of these professional groups becoming involved, such as being unable to attend meetings during school/surgery hours. However, there was anecdotal evidence that GPs in particular do not see the Think Family approach as part of their role, and that information sharing with GPs is a particular challenge. Nonetheless, schools and GPs are universal, non-stigmatising parts of society, and their engagement in whole-family working would be likely to increase its purchase across all services.

## 9 Practice examples

### Practice example 1: NI - standardised screening questions

(Recommendation 2 - screening)

#### **Background**

The five Project Locality Teams (PLTs) had representation from a range of departments within the health and social care trusts and voluntary sector organisations. The project wanted to ensure that the Think Family model was embedded from the outset of engagement with a family. It was important to ensure that screening processes elicited the right information, reliably identify and record that information to ensure where appropriate referral or support could be offered to meet families' needs.

#### **Intended outcomes**

The aim was to have in place a system which routinely and reliably identifies and records information about adults with mental health problems who are parents, and their children and family members, thus promoting a Think Family approach when engaging service users and their families. This includes gathering information about:

- family composition e.g. name, relationship, age/D.O.B., occupation/school/nursery
- impact of parent/carers mental health upon children and on family life/routines
- is there a child/young person undertaking caring.

By revising the screening format it will provide a more accurate assessment of need, and promote early intervention/support if required. Furthermore, it was envisaged that this approach should reduce the need for crisis intervention and risks to children, and may alleviate the fear that service users may have about asking for help.

#### **Practical actions**

We asked all services involved to review their current screening and assessment templates to ensure that the topics identified above were included. The aim was to try to develop a shared 'form of words' when obtaining information needed to take a family approach. This included addictions, maternity, health visiting, A&E, mental health, children's social work services and voluntary organisations, and involved in-patient and community services. Gaps and examples of good practice were identified and shared.

#### **What actually happened**

Some organisations identified that they weren't asking the right questions about the family/children, which resulted in them not knowing whether a person had a family or not. Subsequently, amendments were made to organisations'/departments' screening processes. Participating voluntary sector organisations also reviewed their systems, and made changes to promote the Think Family approach. Organisations were able to insert their own format for retrieving that information. This allowed for a flexible approach fitting with the ethos and specific service aims of different organisations.

Now that information is being collected, this will prompt services to look beyond the adult service user/patient to consider the links and needs of their children and family. It will also help professionals to recognise the interplay between the family's situation in the provision of treatment and care, consider the impact of illness on family life, and identify potential need which should appropriate a service response. We also developed a monitoring system which will screen the effectiveness of changes made. These actions were part of the overall methodology to help promote and embed a Think Family approach within health and social care services. To ensure that we support staff to more effectively work in partnership, an Adult and Children's services joint protocol was developed. The protocol sets out the principles and best practice guidelines (Social Care Institute of Excellence, SCIE Guide 30: Think child, think parent, think family: a guide to parental mental health and child welfare. 2009) that staff must consider when responding to the needs of parents with mental health issues (including substance misuse), their children and families. It is set in the context of promoting a whole-family model through a collaborative approach to service delivery and effective communication between all relevant stakeholders. The protocol promotes that families affected by mental health issues may benefit from the provision of support and intervention at an earlier stage, thus preventing children becoming 'at risk' and enhancing recovery.

### **Advice for others**

- We were surprised at how many services providing assistance to adults that didn't ask or consider children and other family members. It is important not to assume that this is being undertaken: you need to explicitly review screening templates and processes with this in mind.
- Making changes to screening templates may require the backing of senior management commitment to make formal procedural/policy changes.
- It is also useful to put in place a monitoring system to see if screening is effective. This could be undertaken through an audit of case files, embedded in supervision, as quality assurance mechanisms are important to ensure that effective screening is being achieved.
- It is important to support staff in making these changes and give them the understanding and skills to do it.
- It is important to also consider impact of existing information sharing protocols.
- Whilst service user/patient confidentiality is important, it should not be misinterpreted as a mechanism to reduce working in partnership with other organisations. Staff may need to be supported in how they work within and across professional boundaries, and recognise that the needs of the family are an important consideration and that fears about sharing information may be an issue for individuals.

## Practice example 2: Signposting – ebulletin

### **Background**

Raising awareness of the importance of a Think Family approach is a crucial first step in encouraging managers and practitioners to change their practice. As part of its general awareness raising around parental mental health and child welfare, Liverpool produced a regular ebulletin about the project.

### **Intended outcomes**

The objectives of the bulletin were to:

- provide clear, easy to understand information about the Think Family implementation group and what was happening in Liverpool
- ensure the publication was accessed by a wide audience
- ensure that the design was recognisable and consistent and promotes the Think Family brand
- help all professionals to start thinking in a Think Family way
- promote the various training initiatives and Think Family events
- ensure cost effectiveness of publication.

### **Practical actions**

The monthly ebulletin was distributed to staff via email, and uploaded to EDnet, the local schools' intranet site. Alongside this, Liverpool has also developed a [dedicated webpage](#) about the project. The ebulletin has a distinctive Think Family branding and is compiled by a local authority Communications Officer who sits on the project steering group.

### **What actually happened**

Seven bulletins have been produced and circulated to staff. The bulletin includes updates and information about the Think Family project, interviews with members of staff involved, and early findings from internal evaluations.

Feedback from a sample of readers of the bulletin was positive, with the majority of respondents stating that the bulletin was useful, informative and clear. The ebulletin has also been externally recognised as being of exceptionally high quality, and won the Association of Social Care Communicators Award.

### **Advice for others**

The bulletin is written in clear accessible language with strong use of graphics, commended by the Association of Social Care Communicators Award judges. Having a local authority Communications Officer lead the work has been vital.



## Practice example 3: Practitioner champions group – North Somerset

### Background

Effective multi-agency working is key to supporting families affected by parental mental ill health. However, research and serious case review findings have shown deficiencies in joint working between services. This includes problems around information sharing and lack of joint assessment.

To improve joint working between practitioners, North Somerset established a 'practitioner champions group'.

### Intended outcomes

The group had the following terms of reference:

- **Highlighting best practice** in joint working between services
- **Learning lessons** from serious case reviews, to link with the Local Safeguarding Children Board (LSCB), and follow through lessons with practitioners
- **Developing mutual understanding** and knowledge across statutory services
- **Furthering information exchange** across agencies, regarding resources, law, eligibility thresholds, and practice developments
- **Highlighting unmet need** and identifying services that may be available
- **Discussing specific cases**, providing peer review, highlighting problems and propagating joint working solutions where these are required.
- **Reviewing implementation** of joint protocol when it is formally adopted by the LCSB, and to ensure that it is widely disseminated across teams in all relevant services.
- **Acting as a link with teams** – 'champions' to take these issues back to their teams, and to bring issues to the group from their operational unit.
- **Fostering a Think Family approach** in accordance with research findings and in conjunction with the SCIE project team.

### Practical actions

Key stakeholders in the mental health trust and children's services were consulted on the role and structure of the group. Representatives from a range of frontline teams across adult mental health and children's services were then selected. An initial launch meeting was held, followed by regular bi-monthly meetings.

### What actually happened

The group meets bi-monthly and is attended by frontline practitioners from a number of services across adult mental health and children's services. There are currently

around 20 members of the group, representing four main staff groups, as shown in the figure below.

<p><b>Children’s services locality teams</b>            Education Welfare            Education Family Support            Assistant Locality Leader            Mental Health Worker            Parenting Co-ordinator            Children’s Centre staff.</p>	<p><b>Children’s services specialist teams</b>            CAMHS            Youth Offending Team, Children’s Social Care</p>
<p><b>Adult mental health – primary</b>            Positive Steps            Wellness Advisor</p>	<p><b>Adult mental health – secondary</b>            Community Mental Health Teams            Community Psychiatric Nurse            Mental Health Social Workers            Family Therapist            Lead Professional.</p>

Since it was established, the group has:

- developed a job description for the champions, including their role in sharing information with others in their organisations
- heard ‘a day in the life of’ presentations from various members of the group with different roles
- compiled a bank of information about different services and job roles
- identified issues, particularly regarding training needs, to feed in to the strategic steering group.

Early feedback suggests that the group has been a useful space for people to ask basic questions. For example, many people were not familiar with the acronyms and terminology used in other services, and the group has been a useful forum to clarify structures and terminology. It also provides an opportunity for its members to network and get to know each other.

In the future, the group hopes to:

- collect examples of families falling through the gap between adult mental health and children’s services, to feed back to their respective clinical governance groups
- share more examples of good practice
- undertake job shadowing and ‘buddying’ to better understand each other’s roles.

### **Advice for others**

Support from senior managers is vital in enabling staff to attend meetings and fulfil the role of champion.

Getting 'official status' for the group within the relevant agencies has been challenging. Recently, the group has started reporting to the LSCB as a way of linking in to existing governance systems.

It is also challenging to ensure that the position of champion becomes embedded within people's roles. Useful approaches include embedding in appraisals/objectives and job descriptions.

## Practice example 4: NI communication strategy - positive messages about mental health

### Recommendation 1 - Signposting and access

#### **Background**

In implementing the first recommendation, the project team considered how best to provide information for service users, their children and family members, and the general public in a structured and positive way without further stigmatisation of this client group. We felt that whilst there was a range of organisations - including voluntary sector providers and the Public Health Authority - with information on their websites about mental health conditions and support, we wanted to communicate a positive message about parenting and mental ill health.

#### **Intended outcomes**

- provide information to address public perception about mental health and children's services
- address staff perceptions and develop staff awareness of the full spectrum of services available relating to mental health, parental support and support for children
- help professionals and organisations to identify resources, gaps and duplication of service provision
- promote a positive message about accessing support as a means of addressing the stereotypes, stigma and fears that the public may have about accessing mental health and children's services.

#### **Practical actions**

At the outset, we discussed the messages we wanted to convey to our target audiences and a work plan to progress this. We wanted to make sure we got the right information to the right people, which included practitioners as well as the public. In promoting a positive message about accessing support, we also aimed to highlight the project and the Think Family approach to health and social care. We identified who needed to be involved and set up a communications sub-group. This included the project leads, communications personnel within the health and social care trusts, voluntary organisations, the Public Health Agency, and the Department for Education Northern Ireland (DENI). We also ensured there was IT representation to advise on technical issues. Engaging relevant personnel allowed the project to use existing structures.

#### **What actually happened**

We developed our communications strategy (see appendix 1), which was then written by the project manager and the chair of the sub-group. A communications template/framework was provided to assist us in developing our strategy. The

strategy clearly identified the aims and objectives of the project from an information sharing perspective. The messages that the project was sending to services were coordinated with ongoing existing health promotion activities relating to mental health and children's services within the relevant organisations, such as the trusts, NSPCC, Action Mental Health and Action for Children etc. The strategy was signed off by the Project Board and shared with the five Project Locality Teams (PLTs). An extensive range of actions were developed to ensure the public were informed of the aims of the project and how they could participate. We mapped what information trusts were providing about conditions and relevant services. We identified areas of good practice that could be replicated regionally across the five PLTs. For example, the South Eastern Health and Social Care Trust have a database of mental health services which can be accessed by the public through their website, and we recommended that this be replicated by other PLTs. We ensured that the trusts included a signpost to the 'Mind your head' website and links from each trust intranet site to the Health and Social Care Board's (HSCB) 'Think Family Project' web page. Our project webpage included additional local information relating to the project, i.e. local contacts, events and changes to services delivery. Similarly, Aware Defeat Depression set up a hyperlink between the trust and voluntary organisation pages and the HSCB 'Think Family Project' web page. We set up a regional public information campaign to support mental health and reduce stigma. This information was presented in the local press, and we made links with other events, e.g. No Smoking Day, Mental Health Day, Defeat Depression Day and national campaigns. We set up a series of monthly press releases on relevant topics. For example, in June we presented good news stories on debt and gambling, in July we focussed on managing and dealing with depression and accessing support services, and in September it will be mental health and pregnancy, including post-natal depression. We coordinated other activity using existing material and information. For example, we put leaflets in clinic settings, GP surgeries, and used hospital TVs' banners to promote positive messages about mental health, staying healthy, and getting help if you don't feel well, and also provided information on how to access services for individuals and their families. We also used this process and the media to assist us with engaging service users. We involved service user views and feedback to help inform service improvements.

### **Advice for others**

- It is important to secure communications, health improvement/promotion and IT expertise.
- It is useful to develop a strategy at the beginning phase of the project: we really found it be to an invaluable and essential piece of work.

- Be flexible as the strategy will be altered as things progress, but this process is helpful in developing the needs of the project and provides a structure for forward planning.
- It also helps to identify engagement with relevant stakeholders and ensures that no one is left out. It also makes sure that key stakeholders are informed on a continual and regular basis.
- Involving existing communications personnel within organisations is helpful. They are aware of information and dissemination processes, and will have a list of service user organisations, councils and public interest groups etc. This also helps to share the workload and makes information sharing more effective.

## Practice example 5: Screening - Birmingham cross-checking

### **Background**

A recurring problem in parental mental health and child welfare work is disjointed working between adult mental health services and children's social care. Serious case reviews of incidents in which children have been harmed repeatedly highlight a lack of checking between services, to see if a child at risk has a parent or carer known to adult services, or if an adult with significant needs is a parent or a carer to children.

### **Intended outcomes**

To try to tackle this, Birmingham are introducing a system: whenever there is a child protection enquiry (also known as a Section 47 enquiry), a staff member from children's social care will automatically check with adult mental health services to see if any members of the family are known to them. A similar check is made when an adult is referred to Birmingham's mental health Home Treatment Team. At that point, children's social care services are contacted to see if they have knowledge of the family. Referrals to the Home Treatment Team were chosen as a trigger because the numbers were felt to be manageable for staff, while still capturing people likely to be living with children.

The aim is to identify families where joint working may be of benefit, and to minimise the chances of services only addressing a part of a family's needs. The cross-checking is not based on an assumption that all parents with mental ill health will be a risk to children, but on evidence that some sometimes are, and that whole-family approaches can benefit families whatever their level of need.

### **Practical actions**

A lot of the preparatory work involved liaising with local Caldicott guardians (NHS professionals responsible for managing the confidentiality of patient information), and their children's social care equivalents, to make sure that the checks do not breach the rules on information-sharing. For children's services, making checks at the point of a section 47 child protection enquiry is not an issue. Section 47 is a significant threshold for a case to reach, and information-sharing about a family becomes paramount. Information-sharing across agencies is mandated in Working Together (DCSF 2010), the key governmental guidance on safeguarding, and the mental health trust in Birmingham is clearly a key player in safeguarding locally. The focus on safeguarding within children's services also meant they were willing to respond to enquiries from the Home Treatment Team.

### **What is actually happening**

In children's social care, the First Response Team (the local duty system) has the responsibility to make the check with adult mental health services when a section 47 enquiry comes through. In the Home Treatment Team, staff contact children's Integrated Access Team to see whether children's social care are/have been involved.

## **Advice for others**

Working with Caldicott guardians and information-sharing leads is vital to getting this sort of cross-checking up and running. The practicalities of the checks - who will do them, will it be a team task or the role of one person, is it to be done by phone or via computer - all need to be addressed. It is important to consider cross-checks not just for parents, but for anyone living with a child.



## Practice example 6: Understanding the needs of children in Northern Ireland

(Recommendation 3 - assessment)

### **Background**

The UNOCINI (Understanding the Needs of Children in Northern Ireland) is a regional comprehensive assessment process also used as the basis for referrals to statutory children's services to identify the needs of children, based on 12 domains. A review of the UNOCINI guidance for staff highlighted that parental mental health wasn't explicitly covered. It did not provide for the detailed elements of parental mental health that staff need to consider when completing an assessment and the factors affecting parenting when a parent has mental ill health, for example, nature of illness; compliance with medication; frequency of illness; insight into condition; insight into children's needs; supports that are available to the family etc.

### **Intended outcomes**

As part of the project, we wanted to revise the UNOCINI and associated guidance to better reflect what should be included in an assessment when a parent has or may have mental ill health. The aim being to ensure the Think Family approach would be incorporated into all assessments and therefore embedded into practice.

### **Practical actions**

A working sub-group was formed which included representation from relevant agencies and services who were tasked with writing an addendum to be added to the guidance.

### **What actually happened**

Given that the UNOCINI is a regional policy document, it was tabled at the regional Reform Implementation Team (RIT) for approval and subsequently sent to the DHSSPS for authorisation.

### **Advice for others**

You need representation of frontline practitioners from relevant services on the sub-group. It is essential to consult with senior level management prior to the commencement of work, to ensure the review of policy/procedure will be supported and authorised.

## Practice example 7: Screening – Liverpool young carers care pathway

### Background

Young carers can face a range of challenges and need support to help them thrive. If young carers are caring for a parent, then professionals working with the parent are well placed to identify their needs and refer them for support. However, many professionals working with adults do not feel confident in doing this.

Because of this, Liverpool developed a clear care pathway for Adult Social Care staff to undertake young carers' assessments. As part of this, they established a system in which young carers assessments were taken to a multi-agency provider panel that could make referrals beyond social care services.

This process was then updated during the course of the 'Think child, think parent, think family' project. This care pathway was welcomed by staff and also won an award.

### Intended outcomes

The intended outcomes of the revised care pathway were to:

- clarify the process for assessing and referring young carers
- make links with the Common Assessment Framework and Team Around the School processes
- facilitate young carer's access to support services such as education welfare, educational psychology, outreach support and Barnardo's Action with Young Carers.

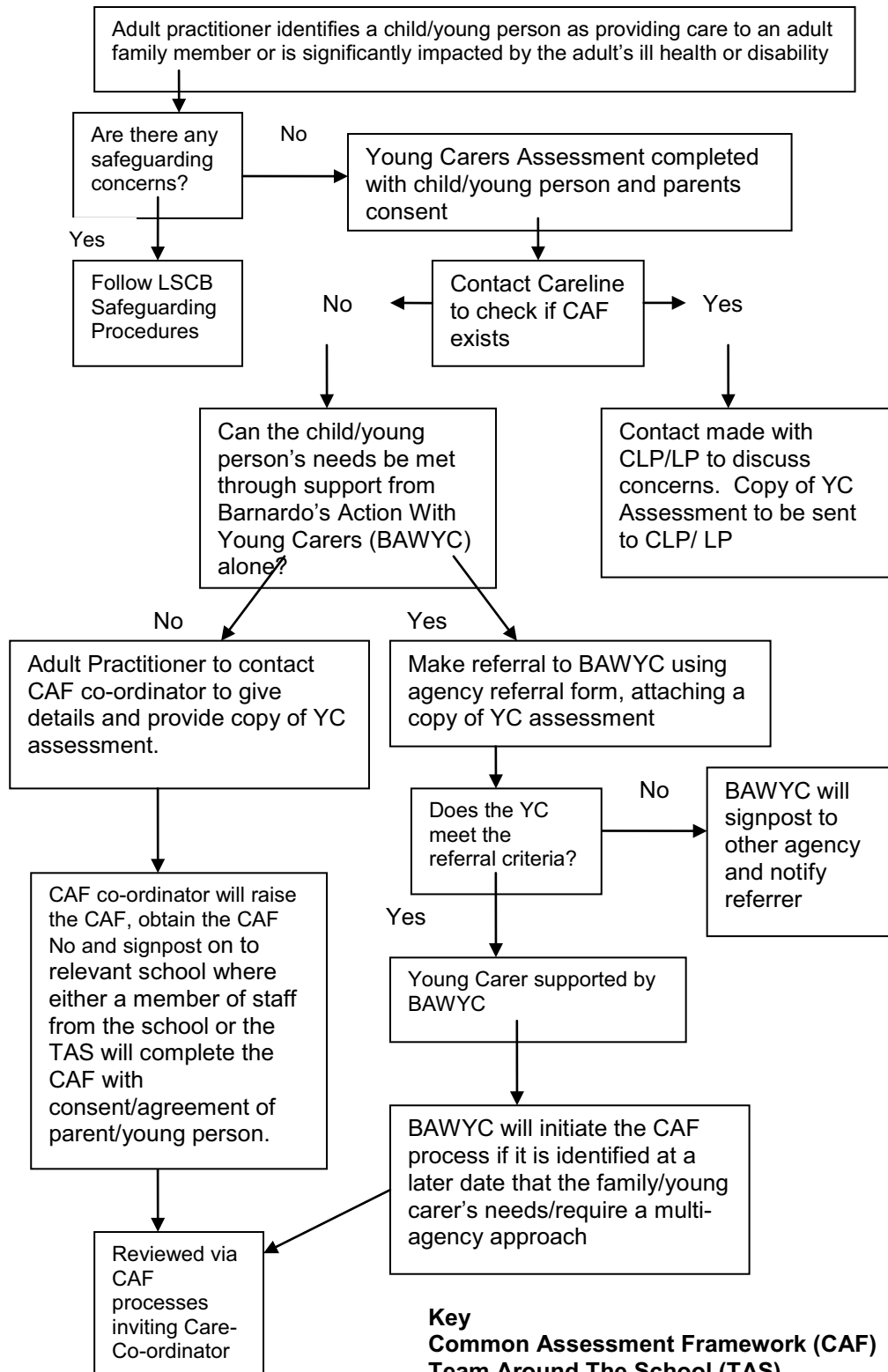
### Practical actions

A group was convened to look at the new referral route for young carers, working closely with the CAF Co-ordinator in Liverpool.

### What actually happened

The group developed the care pathway shown below:

## Care Pathway for Young Carers in Liverpool



- Key**
- Common Assessment Framework (CAF)**
  - Team Around The School (TAS)**
  - CAF Lead Professional (CLP)**
  - CAF Lead (CL)**
  - Liverpool Safeguarding Children's Board (LSCB)**
  - Barnardo's Action with Young Carers (BAWYC)**
  - Young Carer (YC)**

The new care pathway has the following key difference from the old pathway:

- A referral is now automatically made to Barnardo's young carers' service.
- Consistent checks are carried out.
- If the young person does not have a CAF already, then contact is made with the CAF Co-ordinator to arrange for a CAF to be undertaken.
- Resource allocation on the basis of the needs identified in the CAF is now undertaken by Teams Around the School. These teams have a wider representation of professionals on them so should hopefully have the effect that young people have access to a wider range of services, and are more likely to receive the service appropriate to them.

### **Advice for others**

Involving the CAF coordinator was key to ensuring successful integration of young carers' assessments and CAF.

Training is needed to support workers in putting the new pathway in to practice.

## Practice example 8: Planning, providing and reviewing care – North Somerset complex case discussions

### Background

Children's centre staff have long held monthly meetings with health visiting teams. They requested adult mental health input into these meetings, to break down silo working and improve their understanding about mental illness and how best to support families where parents have mental health problems.

### Intended outcomes

The aim of the case discussions is to prevent or mitigate the deterioration of mental illness in parents and carers, and any attendant risks to children. This is done by improving communication between agencies, and developing joint assessments and interventions. In turn, this means staff develop new skills and experiences, and feel supported as they tackle complex case work.

### Practical actions

Regular meetings take place across North Somerset between children's centre staff, health visitors and adult mental health specialists who work within the children's centres. The support of senior management in children's social care in encouraging children's social workers to also attend the meetings has been key to their success.

### What actually happened

Most usefully, people actually got together. Information is shared, and coherent joined-up plans have been developed. The adult mental health specialists within children's centres are able to liaise between adult mental health and children's services, and put children's centre workers in touch with Community Mental Health Team (CMHT) care coordinators. This improved liaison and signposting has led to better attendance at joint meetings and more joint working.

The case discussions are evaluated on a simple scale (1 = useless – 10 = very helpful) and people are asked to explain why they chose the score they did. To date, evaluation is extremely positive, with all agencies agreeing that discussions are constructive in managing risks, supporting families to move forward, and understanding the wide family context in which individuals live and operate. Staff also report feeling supported and validated in what they are doing, and develop a greater understanding of the pressures and constraints of colleagues in different agencies.

People from the wider services system, such as the police, Child & Adolescent Mental Health Services, drug and alcohol services and so forth are invited to contribute as appropriate.

### Advice for others

Getting support from managers, so that people are freed up to attend meetings like this, is crucial to making them work. Similar multi-agency engagement can be

achieved in different ways, for example having children's centre staff attend CMHT meetings. Either way, it is a straightforward and effective method of breaking down barriers and improving joint working with families.

## Practice example 9: Assessment, care planning and review – Liverpool family-centred care pilot

### Background

Liverpool's implementation group established a number of sub-groups to address specific areas of whole-family working. One, the Family-Centred Care Group, looked at how effectively systems and services worked together to support families affected by parental mental health, and what the frontline barriers were to joined-up working.

The sub-group set out various options to improve things, including employing care 'navigators' to help families and professionals find their way around the care system, and a discrete team for whole-family working. In order to limit expenditure, but also to ensure that the Think Family message became widespread, the group decided to focus their efforts on enhancing current provision by making systems and care pathways more amenable to whole-family approaches.

### Intended outcomes

Parents and children had consistently fed back to professionals that they valued staff who worked collaboratively with one another, and with them. The Common Assessment Framework (CAF) was cited as a tool that helped professionals work well together, while keeping their focus on the family.

With this in mind, Liverpool decided to seek better outcomes for families by piloting a new approach to the CAF in one Community Mental Health Team (CMHT) in the city. The intention was to test out on the ground what gets in the way of joined-up working, and whether the increased use of the CAF, especially amongst adult mental health staff, was one way to surmount these obstacles. Focusing on the CAF was favoured because it is a holistic assessment with the potential to address the issues faced by all family members. Liverpool planned to then evaluate the project, and use what was learnt to inform the development of a joint working protocol for supporting parents with additional needs and their children.

### Practical actions

The pilot ran for six months in 2011. CMHT staff received training in the SCIE Think Family approach in children's services thresholds and in the CAF. From there, the CMHT piloted a system whereby if professionals had any concerns about children or families, they would complete a pre-CAF. The pre-CAF is a two-sided form which captures basic information about a family, and adult mental health staff would send this to Liverpool's CAF coordinator, who would then liaise with children's services in order to have the full CAF completed. The adult mental health worker then would join with the children's staff to work collaboratively with the family.

## **What actually happened**

The initial stages of the pilot saw 10 pre-CAF referrals from the pilot CMHT, which represented a very strong engagement with children's services, and the formation of a 'Team around the Family' in a number of cases. There were some initial procedural glitches with IT, and with CMHT staff not getting an acknowledgment of their referrals, but these are just the sort of issues pilots are designed to pick up on.

CMHT staff found the pre-CAF a manageable means to link up with children's services, and more importantly, using it meant that their referrals and their concerns were addressed. In the past, referrals to the main children's social services line were often bounced back as not meeting thresholds. By making use of the CAF system, adult staff found a way to access support for the families they were working with that they had not made use of before. The success of the early pilot stages has led to interest within the council of rolling the model out to adult occupational therapy, physical disability and sensory impairment services.

## **Advice for others**

Training, and then supporting the workforce to apply their learning, was essential to the pilot. The training gave adult staff a much clearer sense of the intervention thresholds in children's services, and helped dispel some myths about the barriers faced by adult professionals in accessing services. The training also provided practitioners with the evidence for them to understand the benefits of undertaking pre-CAFs and engaging in 'Team around the Family' meetings, not only for them as practitioners but also for families.

Identifying that improving joint working with children's services involved only a small change to working practices – merely altering where a referral was directed – was a significant element in the pilot's success.

It was also important that the council and the mental health trust were very clear in their commitment to this work, learning from it\* and making changes as a result of the learning. Senior managers within the mental health trust recognised that for family-centred work to flourish, their processes needed to be compatible with it. They therefore championed the pilot, and championed too the CMHT team manager in his work of supporting staff, through supervision and team meetings, to take a family perspective. This senior backing helped create a sense that the efforts expended putting the pilot in place would be worth it, because the pilot was clearly only one of a number of Think Family initiatives in the city.

The focus of the pilot was very much on how adults' staff link up with children's services to foster whole-family approaches. Work may also need to be done on easing the referral pathway from children's staff to adult services.

\*At the time of writing, the full evaluation report on the pilot is not available. This practice example will be updated when the evaluation is complete.



## Practice example 10: Planning, providing and reviewing care - embedding staff across teams

### Background

Children's Centres can play an important role by promoting good mental health, providing early intervention, and delivering or connecting to support provided for parents with mental health problems and their children. However this role is challenging. Not all Children's Centre workers have the specialist knowledge required to identify parents with mental health problems, and may find it difficult to negotiate complex mental health service pathways.

Two of the sites, Liverpool and Southwark, have introduced new posts to improve links between mental health services and Children's Centres. These use two slightly different models to achieve similar aims. In Liverpool, Family Support Workers were attached to Community Mental Health Teams (CMHTs). In Southwark, a team of senior adult mental health workers worked across the Children's Centres in the Borough.

### Intended outcomes

Both projects had similar intended outcomes, namely:

- improving early help and identification
- promoting good mental health amongst parents
- improving awareness and skills in relation to adult mental health within Children's Centres
- improving pathways of care between adult mental health and children's services.
- increasing numbers of parents with mental health problems who are registered with, and make use of, their local Children's Centre.

### Practical actions

In Liverpool, four Family Support Workers were recruited, based in each CMHT. This was initially on the basis of a 12-month pilot. The aim was for them to focus on working with parents receiving a service from the CMHT who had children aged 0-5, linking in with Children's Centres. The FSWs were commissioned by the central Sure Start Children's Centre Unit but line managed within the mental health trust. The workers receive additional reflective practice supervision from a senior clinical psychologist.

In Southwark the work is delivered by a 'core team' of three senior adult mental health practitioners. One oversees the project, and is responsible for clinical supervision. The other two practitioners cover Children's Centres in the north and south of the Borough, respectively.

The team is funded by Southwark Council's Children's Centre programme, and managed by South London and Maudsley NHS Foundation Trust. The team take

referrals from across the Borough and work with parents experiencing mental distress who would not meet secondary mental health thresholds, as well as those already in touch with secondary services.

### **What actually happened**

The project in Liverpool is now reaching the end of its 12-month pilot, and is being evaluated on an ongoing basis. The workers have so far worked with 140 families, supporting them in a wide range of issues – from parenting and support for young carers, to helping parents build their confidence and find paid employment. The funding has been extended until March 2012, with the PCT jointly funding the project from April 2011. In line with the PCT request, the criteria for families accessing family support has broadened to encompass children of any age.

The workers in Southwark have been in post since 2006, and an evaluation report of their role has been produced. It was found that the specialist adult mental health workers have played a positive role in:

- providing advice and consultation to other professionals, including help staff to understand client diagnoses and brokering access to assessment and treatment
- direct work with parents with mental health problems via home visits, drop-in clinics and planned appointments
- referring parents on to specialist mental health services, and other related services such as domestic violence support services
- providing training for children's services staff in basic mental health issues
- co-facilitating groups such as fathers' groups, stress management groups and a therapeutic mother and baby group.

### **Advice for others**

Both initiatives have been developed within the context of an overall Think Family strategy, which helps to ensure that the roles are valued by senior managers.

It is also beneficial to have a genuinely multi-agency steering group to guide the project's development, as well as commitment and 'buy in' from the host agency.

## Practice example 11: Planning, providing and reviewing care – therapeutic toddler group

### Background

In Southwark, it was identified that there was a gap in assessing and supporting parents with mental health problems *along with* their children. This was particularly the case for parents who did not meet the threshold for Community Mental Health Team services. A therapeutic ‘stay and play’ toddler group, based on the Anna Freud model, was established at a local ‘One o’clock club’ for parents.

### Intended outcomes

The aim of the group is to support and assist parents with significant mental health problems, and to offer advice on the ordinary problems of parenting such as managing exhaustion, ‘baby blues’ and issues with self-esteem and confidence. The group aims to provide a therapeutic environment, in a relaxed group setting, centred around normal play activities.

Originally, it was intended that parents would attend the group for six to eight weeks and then be referred on.

### Practical actions

The group was established by Child and Adolescent Mental Health Services (CAMHS) staff. It now also receives input from the specialist mental health team who provide advice and support to Children’s Centres.

Parents can be referred from a range of services, or refer themselves. Prior to joining the group, parents receive a joint assessment in their home from a member of the Parental Mental Health in Children’s Centres team and from CAMHS.

### What actually happened

The group has been running for about six years. It soon became apparent that a model of time-limited involvement would not be appropriate: it sometimes took a long time for parents to fully engage, and, when they did engage, there was demand for ongoing support from the group. The group has been mainly attended by mothers, although some fathers have also been referred.

The facilitators work with parents to help them think about their relationship with their child and how this affects the child’s behaviour and their own mental health. The therapeutic approach is based on the Anna Freud model, although this aspect is deliberately downplayed and the parent and toddler group aspect is emphasised. The facilitators also provide outreach: visiting parents in their homes before they come to the group, or collecting people to come to the group. Referrers to the service have particularly emphasised the benefit of this for hard-to-reach parents.

### Advice for others

Embedding the therapeutic work within a relaxed parent-toddler environment has been a successful model.

A time-limited engagement period may not work – once parents are engaged they prefer to have ongoing support.

Joint working between CAMHS and adult mental health (via the specialist Parental Mental Health in Children's Centres team) has been particularly beneficial.

## Brief practice example 12: Increasing young carer involvement in reviews/schools charter mark – Lewisham

Lewisham has a strong record of involving the carers of people with mental health problems in Care Programme Approach (CPA) meetings, at which the needs of the person experiencing mental illness are discussed and reviewed. Involvement in the 'Think child, think parent, think family' project, however, highlighted that the views of young carers about their parents' mental illness were not being heard. One obvious problem was that CPA reviews, like most meetings, were taking place during the school day, making it impossible for young carers to attend.

Lewisham therefore included shifting CPA reviews to 4pm in their action plan, so that if they wished to, young carers could come. There are benefits to both the young carer and to the family as a whole in including the young carer in discussions about a parent's mental illness, and in supporting the family as a whole to be resilient. Psychiatrists in one Community Mental Health Team decided to pilot a shift in their working practices to accommodate the change, agreeing also to hold meetings in convenient places for the family, such as their own home.

This initiative built on work by Carers Lewisham and Lewisham to promote awareness of young carers' needs in schools, by awarding a Charter mark to those schools who listen to, value, and support young carers.

## Practice example 13: Strategic – Lewisham protocol

### **Background**

Lewisham produced a protocol on supporting families affected by parental mental illness in 2005. It tended to focus on the 'sharp end' of the safeguarding continuum, and on relationships between statutory services.

### **Intended outcomes**

The aim was to produce a more comprehensive, updated protocol, incorporating the views of young carers and parents with mental health problems. The protocol takes account of early intervention work and the Think Family agenda. Obviously, the ambition is to keep the protocol as a document that is used and applied on a daily basis, so there was also a focus on producing a brief statement of principles and approaches that people could readily digest.

### **Practical actions**

The first step was to hold a stakeholder event – for parents, young carers and adults' and children's professionals - to get the concept of Think Family and of joint working at the forefront of people's minds. For the protocol itself, the main structure was borrowed from that of Southwark, a neighbouring borough that shares a mental health trust with Lewisham, and which was also a SCIE Think Family pilot site. A Lewisham steering group member was identified to rework the protocol, and drafts were circulated to the steering group for initial comment. Steering group members undertook to share the drafts with their sector – Child & Adolescent Mental Health Services (CAMHS), family charities, young carers' workers and so on. The drafts also went to the local group of parents with mental health problems set up to support the pilot project in Lewisham [see Practice Example 19], so that the user perspective could be included at an early stage. The protocol was discussed by the parents at a meeting with the author, who adapted the protocol as a result, and who also incorporated the young carers' perspective using Barnardo's consultations messages.

The protocol was also presented to a roundtable discussion of children's social care and adult mental health managers, as they more than anyone will have responsibility for its application in daily practice.

### **What actually happened**

The protocol contains a theoretical framework for whole-family interventions, and links to practice and policy guidance. It also sets out practical steps for professionals, such as referral routes, details on information-sharing, and what to do for families at each stage of a care pathway. At the time of writing (August 2011), Lewisham is planning to promote the protocol more widely - to housing, the police, education and others - prior to an official sign-off and launch in December 2011.

## **Advice for others**

Identify if neighbouring areas have documents that can help. There is no virtue in reinventing the wheel. It can also save time to have one author, who then reports back to a group, rather than have the group try to compose the document itself. Involving users – including young carers – is vital if a document such as a joint working protocol is to have relevance and traction. Thought needs to be given to how to bring such consultations alive: ploughing through the document line-by-line is unlikely to be successful. Lewisham had more success by focusing on broad themes and outcomes the users were seeking from integrated working. Acknowledging the input of all the contributors, including users, is important.

To ensure a protocol has purchase, senior backing is important: Lewisham are seeking mayoral input at the launch, as well as formal sign-off from strategic groups. The protocol needs to be used, of course, and the sign-up of frontline managers is important, as is building in an annual review of its use and its contents, to ensure currency. This gives a protocol a fighting chance of changing practice and changing attitudes.

## Practice example 14: Strategic – Southwark advice and liaison role

### Background

There had been a number of improvements to joint working between adult mental health and children's services in Southwark. However, there were some enduring concerns around:

- poor communication between the two services about concerns, risks and significant activity
- mutual negative stereotypes between children and families workers and mental health workers
- a lack of understanding of roles and responsibilities
- a failure to understand the professional and legal context in which workers operate.

The London Borough of Southwark and South London and the Maudsley Trust therefore put forward a proposal for a senior member of staff, working across children's and adult mental health services.

### Intended outcomes

It was proposed that the post holder would lead on service development and best practice, working directly with professionals in children's services and adult mental health.

It was intended that this, in turn, would improve:

- identification and multi-agency management of children of parents with mental health problems where there are safeguarding issues
- adult mental health practitioners' management of the needs of children
- Children and Families Social Workers' understanding of the impact of parental mental health on children
- coordination of assessment and work across services.

### Practical actions

A post holder was appointed in May 2009 and jointly funded by the local authority and mental health trust. The post is at Band 8A, or Head of Service level. The post holder works across the Children's Social Care and mental health services, whilst retaining line management responsibilities for the Parental Mental Health in Children's Centres team.

### What actually happened

The role has developed in response to local needs, and focuses on areas such as:



- **Strategy development** – helping to develop new structures and processes to support safe joint working across mental health and children’s services, including taking account of this as services are restructured. Support the ongoing developments regarding a Think Family approach
- **Case consultation** to professionals from adult mental health, including Improving Access to Psychological Therapies (IAPT), children’s services, midwifery and domestic abuse services, including input to the Multi-Agency Risk Assessment Conference (MARAC)
- **Safeguarding groups** – attending local Safeguarding Children Board and individual safeguarding groups, such as those attached to hospital maternity services.

### **Advice for others**

The role needs to be senior enough to have confidence to make decisions regarding information sharing, making referrals and providing clinical/safeguarding advice. Joint funding is helpful as it promotes ownership from both services.

## Brief practice examples 15: Workforce development

### Drama-based learning in North Somerset

North Somerset held a safeguarding conference, looking to highlight the impact of parental mental health on children and young people. A local theatre group, Eyewitness Theatre Company, facilitated the day.

Sixty delegates from a variety of agencies attended, including schools, adult mental health services, adults' and children's social care, youth offending teams, solicitors, health services and the voluntary sector.

The theatre company performed vignettes showing a variety of scenarios, focusing on different aspects of parental mental illness, and the impact on children. Delegates found the vignettes powerful and moving, and having the scenes acted out added a new aspect to people's learning. The theatre company led group activities following each drama, asking delegates to reflect on what they had seen. The scenarios helped delegates to identify the practice issues present, and to explore how different organisations could work together more effectively to address them.

Feedback from the event was overwhelmingly positive, and to try to ensure what was learnt made an ongoing difference, delegates were asked to feedback four months after the event, and all said they were able to put into practice learning from the event.

"The course really brought situations to life as you would have to deal with them at work."  
"Enjoyable, useful, interactive form of learning with professionals from other agencies."  
"Highlighted my awareness of the need to ensure communication between agencies."  
*Delegate feedback*

### Meriden training – Birmingham

The Meriden Family Work Programme based in Birmingham, has been promoting family-sensitive mental health services since 1998. The Birmingham project team commissioned Meriden to run nine sessions of training for adult mental health and children's social care staff, looking at the practical applicability of whole-family approaches in mental health. Managers had a separate training session, to encourage their buy-in to the new ways of working. The Meriden sessions built on Think Family training for 150 duty and assessment workers in children's social care, and the embedding of Think Family messages in children's and adults' safeguarding training.

## Liverpool lunchtime learning sessions

The team in Liverpool decided to raise awareness of the Think Family approach by holding 'lunchtime learning' sessions for staff from a range of agencies. The sessions were held during lunchtime at eight different locations across the city.

The aim of the sessions was to introduce staff to the 'Think child, think parent, think family' guide, and how it was going to be implemented locally. The sessions were delivered to multi-agency staff groups, meaning that they were also an opportunity for staff to meet and network.

Nine sessions were attended by a total of 252 staff from agencies including:

- the local authority
- NHS Foundation Trust
- mental health trust
- community and voluntary sector
- PCT.

*"I enjoyed the multi-disciplinary approach of the event, promoting working across boundaries."*  
(Lunchtime learning participant)

A survey sent out to participants following the sessions showed that four in five (82 per cent) thought that attending the session had increased their understanding of Think Family concepts and messages.

## Practice example 16: Workforce development – Family Partnership Model training

### Background

Southwark provides a number of training opportunities for staff working with parents with mental health problems, including statutory safeguarding training for mental health practitioners and Crossing Bridges training.

However, a need was identified locally for training for adult mental health practitioners that went beyond safeguarding responsibilities.

The Family Strategy Group commissioned the Centre for Parent and Child Support to train adult mental health practitioners using the Family Partnership Model (2002). This model had previously been used largely for professionals working primarily with children and families. The model was therefore adapted for use with adult mental health staff.

### Intended outcomes

The Family Strategy Group's intended outcome of the training was to provide staff with a conceptual framework and a set of skills for working in partnership with parents with mental health problems, in particular to:

- see service users in a family context – as parents and potential parents
- be mindful of the needs of the children of their clients including, but not restricted to, their safeguarding responsibilities
- build supportive, purposeful relationships with service users. This also helps to facilitate the above two roles.

### Practical actions

The training was adapted for use with mental health staff by a group including one of the model developers, a service user advocate and mental health professionals. This resulted in the 'adapted Family Partnership Model' (2009).

The training was then piloted with a group of nine staff from a Community Mental Health Team. The training was delivered by three trainers, one of whom is a parent and has previously used South London and Maudsley (SLAM) NHS Foundation Trust services.

A year later, a second cohort of training was delivered by the same service user advocate and another trainer from the Centre for Parent and Child Support. The training was attended by eleven practitioners from a range of teams within SLAM.. The training was delivered in five one-day sessions across a five-week period. This model of delivery was chosen in order to optimise attendance and also to give practitioners adequate time between sessions to reflect and start to embed the model in their practice.

## **What actually happened**

The training was evaluated to assess participant reactions and the impact it had had on their practice.

Initial reactions and perceived changes in attitudes, skills and knowledge were evaluated using self-completion questionnaires at the end of the training. Interviews were also conducted with nine practitioners who had taken part in the training: six from the first cohort and three from the second cohort. These were undertaken approximately 18 and six months respectively after the training had been completed. Focus groups were held with parents to discuss their perceptions of practitioners' practice following the training. Recruitment for the focus groups proved challenging for both cohorts. However, following a mailing of all clients of the team involved in the first cohort of training, two focus groups were held. For the second cohort it was not possible to convene groups and so individual interviews with parents were held instead.

The evaluation showed that the training had a positive impact on practitioners' knowledge and skills in terms of:

- gaining new knowledge (for example, relating to parent-child dynamics)
- refreshing knowledge they had gained at other points, for example during their professional training
- putting a structured framework around skills they already had in relation to working with families.

The training also led to changes in practice in terms of:

- practitioners' awareness and involvement of children of their clients
- their understanding and 'use' of their relationship with their client
- exploring and clarifying situations
- agreeing and reviewing tasks with clients.
- 

Service user involvement in designing and delivering the training was valued by the participants.

## **Advice for others**

Family Partnership Model training should be delivered by an appropriately trained professional and, if possible, a parent who has used mental health services. Ongoing support after the training is vital. Here, regular group reflective practice sessions have proved to be very important in continuing to build people's confidence and skills in using the model.

As part of this, it is helpful if team managers can be trained, as well as frontline practitioners, so that they can provide support and leadership for the approach.

Both trainers felt that it would be helpful for trainees to have more preparation before starting the training. It was suggested that this should be in terms of:

- thinking about a family with whom they are working, who they can 'keep in mind' during the training
- thinking about what they would like to get out of the training.

The focus groups with parents are an important part of getting feedback on the effectiveness of the training. Parent focus groups need to be built in to the recruitment and preparation for the training as a whole. It was felt that recruitment of parents would be best done face-to-face by participants in the training, so it would help if the trainees were aware of this from the outset.

## Practice example 17: NI knowledge and skills framework

### Recommendation 8 - workforce development

#### **Background**

As knowledge and services expand, health and social care systems and practices change in response to society's needs and therefore the roles and responsibilities of health and social care staff evolve. Therefore, periodic review and updating of staff skills and knowledge is required to ensure their currency reflects these changes. The project identified that there wasn't a consistent approach to the training and development of staff working across this interface. The development of the knowledge and skills framework was informed by the Think Family model approach to provision and delivery of care as outlined in the SCIE guidance.

#### **Intended outcomes**

A framework was developed to inform health and social care trusts and voluntary organisations in the planning, commissioning and delivery of a training programme that would meet the learning and development needs of staff working across the mental health and children's services interface. The framework also aims to:

- provide guidance and assist in the standardisation of the approach to service delivery
- inform education providers
- provide support to and develop staff competency when working with parents who have mental ill health
- improve quality care and support in the management of risk
- be used by individual practitioners and/or managers to assist in identifying individual learning and development needs.

#### **Practical actions**

A working sub-group was established with representation from all relevant services - including training departments - at a pre- and post-registration level across relevant professions; including social work, nursing, medicine and allied health professions. For the purposes of this project, it was designed to meet the needs of the statutory sector, but in the design we were cognisant of the training needs of voluntary sector staff. We designed the framework so that it can also be used to address the needs of both professional and non-professional staff and, where possible, fit with existing training programmes. This document sets out the skills and competencies needed by health and social care professionals working with parents with mental health problems and their families.

## **What actually happened**

The sub-group developed the content, and the framework was written by the project manager. It was distributed for wide consultation, feedback provided informed the amendments made, and the framework was subsequently sent for consultation and then finalised. The framework was designed with regard to the different level of learning needs required by staff, related to their level of responsibility and contact with families. It was signed off by the board members of the Health and Social Care Board (commissioners) and will be implemented across the five trusts with an implementation plan, which identifies who needs to complete the training, at what level and at what stage of their career. The project managers also linked with education representatives for social services, mental health, nursing and medicine (both at under- and post-graduate level), to raise awareness about the project, and discuss ways of including Think Family in higher and professional education.

## **Advice for others**

- Allow plenty of time to develop the framework. To try and review a training strategy to meet the needs of staff in medicine, nursing, social work, allied health professionals and non-professional staff in one framework is a complex and challenging task.
- Awareness of the family model approach should be introduced to staff at the earlier opportunity in their training, including pre-qualifying training such as undergraduate and postgraduate health and social care courses.
- In designing the framework you need to consider resource implications to ensure that the training can be delivered. However, this should not detract from the standards of practice necessary as identified in the framework. Barriers to delivering training should not deter from good practice, and other means of delivering training could be explored (e.g. in-house, at team meetings etc).



## Practice example 18: Creating a successful steering group – Liverpool & Southwark

### Background

All of the implementation sites put together, with SCIE's support, a steering group (sometimes called project or implementation group) to devise an action plan to implement the recommendations of 'Think child, think parent, think family'. There was little specific guidance as to who should sit on these steering groups, although the guide's emphasis on senior involvement in making the necessary changes to practice made the presence of senior managers desirable. The guide also touches on the involvement of families themselves in service improvement, and the action plans all had sections on user involvement. It therefore seemed beneficial to include service users or their representatives on the steering groups.

### Intended outcomes

The aim of all the steering groups was to formulate, and then act upon, a plan to put into practice the key recommendations that were most pertinent to the local situation.

### Practical actions

All of the sites put together dynamic and effective steering groups. In Liverpool, the group had by and large worked together for some time in advance on the implementation project, and was chaired by senior staff. For most of the project, it was chaired by the Assistant Director for Children's Services, and in the earliest stages was jointly chaired by adults' and children's assistant directors. In addition, the group included a participation lead from mental health user groups, and a Barnardo's young carers' service development worker. Southwark had a well-established mental health family strategy group, chaired by a director of services, which took on the steering group role for the implementation project. It too included people who had used mental health services themselves.

### What actually happened

As groups who had worked together before, the steering groups in Liverpool and Southwark were able to get going on their action plans more quickly than those steering groups which were coming together for the first time. In these latter groups, early meetings tended to be focused on people getting to know each other and each others' roles, and learning to function as a team. In some cases, this meant overcoming some degree of organisational distrust and lack of awareness that had developed over time. Southwark and Liverpool, to an extent, avoided this and worked more effectively from that start, which in the context of a two-year implementation project was a real bonus.

The effectiveness of these groups was also linked to being led by senior managers. The presence of senior managers on the groups sent a message that this was work which needed to be prioritised, and other people's attendance at the meeting tended to be consistent as a result. It was also notable that, in meetings chaired by people in a position to make wide-ranging decisions, actions were completed much more

swiftly. The contrast was between sites where, when an idea was mooted, the response was 'I will check with my manager and report back next month', and those where the manager was in the room at the time, and was able to say 'yes, we will do that.'

Coupled to this top-down authority was a bottom-up dynamism injected by users, user representatives, and voluntary sector staff. Less constrained than others by the bureaucracy of large statutory bodies, these steering group members brought a valuable frontline perspective and a flexibility about what could be achieved. This consistent combination of senior staff, and voluntary sector and user group members, many of whom had worked together for some time, seemed to be what made Liverpool and Southwark steering groups effective.

### **Advice for others**

Embedding a project like this in an existing group's work would therefore seem to have the advantage that the group will already have developed ways of working, and will not need to spend valuable time getting to know each other and learning how to work together. If a new group is to be formed, there might well be the advantage of generating the enthusiasm that can come from new developments, but we would highlight the need to allow for time for the group to bed down before it can start to perform effectively.

The right mixture of people is key. All of our sites had committed and creative frontline staff and first-line managers, as well as subject specialists such as communications or workforce development leads. These people were vital to the project's successes. Combining them with senior managers who could ensure that things got done, and people with experience of services who could steer the group so that the right things were focused upon, appeared to be the best recipe.

## Practice example 19: Making it happen - Lewisham user group

### Background

The steering group in Lewisham recognised that, as a borough, they lacked an organised user group of parents with mental health problems. This meant that the work risked being done without the input of the people it was designed to benefit.

### Intended outcomes

The steering group wanted to understand the needs of parents with mental ill health, and their experiences of using mental health services in the borough. The group wanted to reflect and address these issues in the family strategy, joint working protocol, and other Think Family initiatives.

### Practical actions

The group identified parents with mental health problems from within existing user groups and mental health forums. A flyer was developed to explain the nature of the proposed group and the work it would do. It was made clear that people would be paid to attend, from funds set aside to support the Think Family project.

Twelve people agreed to join the group. A local facilitator, Sarah, herself a mother with mental health problems, was engaged to run the group, alongside Nick, a manager from Building Bridges, a voluntary sector scheme that support families affected by parental mental ill health. Nick was part of the wider steering group, and Sarah joined the group to represent the voices of the users. A local children's centre was identified as a suitable venue.

### What actually happened

The user group was set up specifically to advise on the work of the Think Family project in Lewisham, although it was hoped from the start that it would have therapeutic benefits and, in time, address wider issues the parents faced. Initially, eight meetings were scheduled, with each one focused on a particular aspect of Lewisham's Think Family action plan. In one session, the group looked at what training they felt staff needed to work in a whole-family way; in another, they examined the proposed new protocol for Think Family working, to ensure it met their needs as users; in a third meeting they explored how services could support families to be more resilient, and build on their strengths.

It has helped me realise I can do something, e.g go back to university. So I believe people who go through mental illness can do things for themselves. *A parent from the group*  
The group has been like a mentor for me. It helps me. This is very important in my progress. I am leaving more positive ... and receiving good feedback is positive. *A parent from the group*

Wherever possible, the lead steering group professional for the topic under discussion attended the user group meeting, so that the views of users could be heard directly by those charged with making changes. This aspect proved very important to the parents, because it created a sense that they were genuinely being listened to, by people with the authority to make things happen.

This sense of being heard was one feature of the group which has helped it have a tremendous impact on the confidence and well-being of some members. Even more important was the opportunity to share thoughts and experiences with other people in similar situations. This allowed people the chance to be supported, but also to support others, and boost their confidence in doing so.

Group meetings were supportive, informal affairs, with some parents bringing in food they had prepared. The users encouraged each other to share thoughts, and actively worked to support the self-esteem of other members. This enabled some users to come to talk at events about parental mental health, and explore becoming registered as mental health trainers in their local mental health trust.

### **Advice for others**

Creating a supportive environment, led by a user, has proved helpful in bringing the group together. A strong feature has been the presence of professionals working on the topic under discussion, so that there is a clear and direct link from user feedback to actual changes. The joint working protocol, for instance, was altered to reflect the views of users. This made the consultation feel meaningful for people, and boosted their self-esteem because they saw that professionals genuinely were interested in their point of view. Users have been named in Lewisham's documentation as contributors.

## Brief practice example 20 – quick wins and embedding a Think Family approach

The sites have shown that there are some quick and low-cost actions, which can help to start the process of change. These include:

- lunchtime learning sessions
- ensuring that Think Family is included in staff inductions and safeguarding training
- liaison with key staff teams to ensure that practice is supporting a Think Family approach, e.g. that Child in Need risk screens are being completed.

These types of actions have been positive in terms of raising staff awareness from an early stage, and giving a sense of progress and achievement.

Another way of making progress is to embed the Think Family agenda in other work streams and initiatives. There are a number of other policy agendas with which work to support families affected by parental mental ill health can be linked. Linking with other strategies helps to ensure efficient use of resources and the sustainability of the work. Relevant areas include:

- **Hidden Harm** – Hidden Harm strategies are local responses to the Advisory Council on the Misuse of Drugs report on the impact of parental problem drug use on children.
- **Complex families** – We have found that similar approaches need to be taken to improve responses to other kinds of complex families, including parents with substance misuse problems, refugees and asylum seekers.
- **Parenting and early years** – It may be helpful to make links to the local Parenting Strategy. The Allen, Munro and Tickell reviews have also highlighted the importance of early intervention, and many local areas will be working to respond to this.
- **Young carers' strategies** – [The practice guidance to the Carers \(Equal Opportunities\) Act 2004](#) states that local authorities should have 'a protocol, shared between adults and children's services, for identifying and assessing young carers.'

## Practice example 21: Putting it into practice – Southwark parents' group

### Background

Since 2006, members of staff from Southwark Mind, a user-led mental health charity, have been providing a user perspective to the Southwark Family Strategy Group hosted by the South London and Maudsley NHS Foundation Trust (SLaM). Five out of the six Southwark Mind staff members were parents, offering a challenge to the historical assumption that people with severe and enduring mental health issues do not have children. At the launch of Southwark's Family Strategy in 2007, Southwark Mind hosted a user-only workshop, asking parents with mental health problems for their views and experiences. One of the recommendations from the workshop was that a regular safe space be established for parents with mental health needs.

### Intended outcomes

The aim was to offer parents a safe space where their opinions and experiences could be validated by others who have been in similar circumstances.

As well as the parents' groups, parental representation on Southwark's Family Strategy Group was intended to keep the perspective of parents with mental health needs at the heart of local decision making.

### Practical actions

Southwark Mind has run parents' groups funded by SLaM since 2009. The groups are facilitated by two parents who have used mental health services, and run for two hours. Lunch is provided, a complementary therapist works alongside the group, and most importantly there is always a crèche.

### What actually happened

Common themes of the group discussions have included: how to get support before a crisis; managing psychiatric medication with the demands of parenting; changes in psychiatric service provision; and benefits legislation.

The parents' groups ensure that these themes, and parents' current experiences of Southwark services, are represented on the Southwark Family Strategy Group. For example, parents felt that staff needed more training to support them as parents, which led to parental participation in the Family Partnership Model Training, commissioned by SLaM and delivered by the Centre for Child and Parent Support. A parent was involved in the design of the course and one of the two trainers is a parent who has used psychiatric services. The training's objective is to increase staff awareness of child development and the tasks of parenting, to enable them to work in genuine partnership with parents using mental health services.

Parents from the parents' group were also instrumental in developing a staff training film, 'Nobody says congratulations'. The film aims to show service users and parents in their own homes, surrounded by the paraphernalia of family life. Through the

stories of three parents with mental health problems, it provides clear messages for staff in how parents want to be supported. At a recent parents' group, a parent spoke about how empowering she had found taking part in the film, which has a focus on the positive impacts of having a child. She is now less isolated, feels more integrated, and is standing as a parental governor at her child's school.

### **Advice for others**

An important element of the group has been the dual function of providing a safe environment for people to share their experiences, but then also using the awareness that has arisen from that to make practical improvements to services. The opportunity for parents to tell service managers what they needed is highly valued by group members.

It is to be noted that a properly funded parents' group, with a crèche, facilitator, complementary therapist, lunch and a room, does have resource implications. The support provided, however, can be really valued by a significant number of parents, and can prevent the need for more formal, and more expensive, services.

*Unlike all other groups I have been to, in the parents' group everyone has been there and can understand.*

Parent group member

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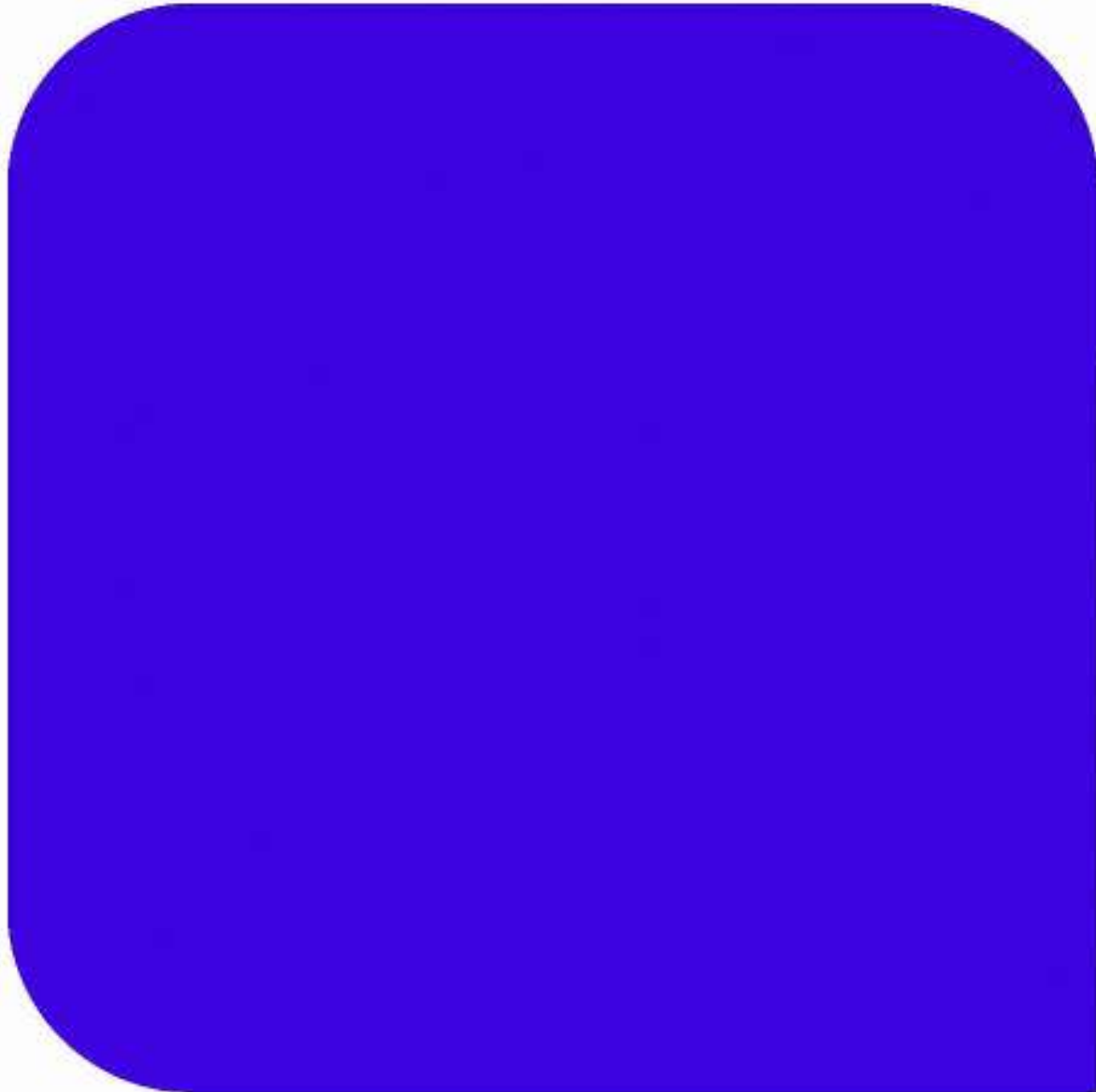
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