

# Parental mental health and child welfare: Report of the practice survey



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## Introduction

In the *Mental health and social exclusion report (2004)*<sup>1</sup>, the Social Exclusion Unit identified parents with mental health problems and their children as one of four groups most likely to face barriers in getting their health and social needs addressed. The Department of Health therefore commissioned the Social Care Institute for Excellence (SCIE) to undertake a systematic review of research and existing practice in this area. The findings from this review are being used to produce new national guidelines in *Think child, think parent, think family: a guide to parental mental health and child welfare*<sup>2</sup>.

As part of this project SCIE conducted several systematic literature reviews and a practice survey. This report summarises the findings from the practice survey, which aimed to:

‘Map existing service responses in detail at key stages of the “care pathways” that both the parent and child experience during their contact with services, for example, commissioning, identification, referral, assessment, carers’ assessment and review, care planning, intervention, review and evaluation.’

The methods used for the practice survey are described on page 2. The findings are summarised on page 3 of this report.

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<sup>1</sup> Office of the Deputy Prime Minister (2004) *Mental health and social exclusion: Social exclusion unit report*, London: OPDM.

<sup>2</sup> Social Care Institute for Excellence (2009) *Think child, think parent, think family: a guide to parental mental health and child welfare*, London: SCIE.

## Methods

The practice survey was carried out in five different sites in different regions of England. They included:

- two adjacent local authorities that are co-terminus with the same mental health trust
- three different local authorities that are co-terminus with different mental health trusts.

The practice survey was carried out in two stages. In Stage one, the project team worked with local consultants in each practice site to conduct:

- a stakeholder 'process mapping exercise' that explored the journey and experiences of parents and their children when trying to access and receive adult mental health (AMH) and children and families (C&F) services locally
- supplementary group and individual interviews that helped to fill gaps that were not addressed by the 'process mapping exercise'
- a review of local data and information about workforce development and service planning, for example, inter-agency protocols, training plans and evaluation reports, service plans and eligibility criteria, performance management data, inspection reports etc.

In Stage two, the project team worked with local consultants to answer questions still unanswered from Stage one, and to explore the key themes and issues arising by conducting:

- individual interviews to address gaps in information highlighted in Stage one
- individual and group interviews to explore previously unidentified issues that had surfaced in Stage one
- a review of the examples of good practice identified by respondents in Stage one.

Stage one of the practice survey was conducted in 2006 and Stage two was conducted between 2006 and 2008.

# Findings

The findings are summarised under the following key themes:

- Commissioning
- Care pathways
- Local service developments
- National development

## 1. Commissioning

### Joint commissioning processes

#### **Is there cross-agency planning/commissioning for parental mental health and child welfare?**

The practice survey found no examples of joint commissioning for parental mental health and child welfare. Even the concept of a joint commissioning forum for this purpose seems far in advance of current organisational thinking. There is some joint commissioning within children's services between health and social care, but children and adult commissioners are very separate.

There are also structural barriers to joint commissioning, but these can be overcome. For example, if the local authority (LA) and primary care trust (PCT) have boundaries that are co-terminus, this significantly helps joint planning.

There is some **cross-agency activity** that is linked to planning services. Examples include:

- an informal forum to develop joint practice protocols across agencies
- a bi-monthly consultative forum for all stakeholders including people and carers who use these services
- joint service planning, for example, adult mental health (AMH) representation at children's 'wellbeing' forums
- specific services commissioned for families, the Building Bridges projects, for example.

#### **What are the influences on commissioning and planning structures?**

Currently, services for families with a parent with a mental health problem are not high on the commissioning agenda. This is because:

- They are not considered a high priority – the drivers for improving outcomes for this group of children and parents are fairly low-key in comparison with others.
- There are no performance indicators to promote service provision in this area. The existing quality and outcomes framework standards for mental health are about assessing and treating individuals.

- Systems for joint commissioning exist but are not yet being used.
- Commissioners are being encouraged to buy evidenced-based interventions only. This restricts their ability to push the boundaries and develop new kinds of service.

Potential levers for change include:

- developing and implementing recommendations from social care regional offices and Local Safeguarding Children's Boards (LSCBs)
- educating/training commissioners to take a holistic approach – so that social, physical and emotional wellbeing are considered together.

Providing evidence of positive outcomes is often the best way to bid for a service or its continuation. Funding needs to be made available for evaluating services, which is separate from the service-delivery budget.

### **How are parents and children involved in the planning and commissioning processes?**

To date, there has been very little involvement of parents and children in planning and commissioning processes. Where there has been involvement this has been limited to consultation, rather than genuine participation.

## **Planning and strategy**

### **Do service planning and commissioning processes adopt a family perspective?**

In the absence of joint commissioning forums, 'family-centred strategy' has not been well developed. There was only one example found of an emerging family and parenting strategy. This was within AMH services.

### **Do these planning and commissioning processes address the barriers to accessing services?**

The problem of access is not being addressed in any systematic or strategic way. There was one example found of a service development aiming to target people who do not easily engage – a children's centre that was developing services for parents with mental health problems. In another area, families are able to receive a service without having to be referred by their GP in order to reduce stigma.

### *Do these processes address the additional barriers faced by refugee, asylum-seeking and black and minority ethnic families?*

Again this issue does not seem to be being addressed strategically. There are no services being planned or commissioned to address the specific needs of black and minority ethnic (BME) families with parental mental health problems. There are only services which address the general needs of BME people who use these services

and their families. The emphasis is being placed on ensuring that the specialist mental health services respond in a culturally sensitive way.

### **Do these processes promote collaboration with other sectors?**

Collaboration with other sectors is underdeveloped and there is little evidence of innovative work in this area. There was only one example found of a community-based initiative that included health, housing, education, social care as well as AMH, child and adolescent mental health (CAMH) and children's services.

## **Needs assessment/local planning information**

### **How is data collected on the number of parents with mental health problems/children with a parent with mental health problems who are known to services?**

This data is not being collected or used in any systematic way. Information about a parental mental health problem is sometimes recorded as part of individual assessments, during serious case reviews, on the Child Protection Register (CPR) and records of looked after children. However, it is not often stored electronically or collated in a way that can be used to inform planning.

#### *What is known about their ethnic background?*

Some general information is available on the ethnic breakdown of people using specialist mental health services, but not in relation to families with a parent with mental health problems.

#### *How does this data inform service planning?*

IT systems have acted as a barrier to collating this information in the past. It is hoped that new systems will improve the situation in future. However, there are concerns about whether such systems will collect the right information, and whether it will be possible to interrogate the data in a meaningful way.

## **Funding specific services**

### **Are any services commissioned specifically for parents with mental health problems and their children? Who commissions them?**

Examples of services commissioned specifically for families with a parent with a mental health problem include:

- in-patient perinatal mental health services commissioned by AMH
- a Sure Start service with AMH workers commissioned by a Children's Trust or Early Years Child Care and Play Partnership
- a young carers' service commissioned by CAMH
- a Building Bridges service commissioned by a children's trust
- a Family Health ISIS (for African and African-Caribbean families) commissioned by AMH.

## **Do commissioners request and fund service providers to evaluate these specific services?**

There were no examples found of evaluations of specific services for parents with mental health problems and their children. Nor do the routine evaluations of more general services include an assessment of the impact on these families.

## **2. Care pathways**

### **Policy and protocols**

#### **What policy, guidance or procedures are in place to:**

*Promote the wellbeing of adults as parents and their children?*

*Identify and reduce risks for children affected by parental mental illness?*

*Identify and increase protective factors for the parent, child and family?*

The general principles of promoting wellbeing and managing risk are supported by the national and local policies that aim to protect all children. Although the need to identify and increase protective factors is also part of national policy, this does not seem to be as explicitly described and embedded in local policies/protocols.

There are few policies, guidance or procedures that address the specific issues for families with a parent with a mental health problem. Instead, these families tend to be considered as a sub-group within more general policies. For example, specific guidance on families with mental illness may be included within a 'child in need' protocol or discussed in the context of more general policies on risk screening. Similarly, local policies may refer to national guidance on child protection that makes specific recommendations about supporting these families.

There are some policies that relate to parental mental health, but only in very restricted, high-risk circumstances, for example, a policy on child protection for acutely disturbed pregnant women.

The general picture that emerges is that there are very many policies that touch on this area (and probably overlap), but comprehensive and coherent policies/guidance/procedures have yet to be developed.

#### **How do agencies ensure such policies are embedded into practice?**

These policies are embedded through joint training or training across sectors. Examples include providing:

- safeguarding children or child protection training for AMH staff
- Crossing Bridges training for both AMH and children and families (C&F) staff.

There are also examples of developing new strategies or making use of clinical governance structures to ensure close collaboration and joint protocols. But in general it seems that agencies are struggling with embedding this guidance and integrating it into the volume of other policies concerning risk, assessment and protection.

*Are such protocols evaluated particularly in terms of the impact on partnership working and the difference made to families' daily lives?*

There were no examples found of regular, systematic reviews or evaluations of the effectiveness of protocols. The impact of such policies is therefore unknown.

### **How have parents and children been involved in the development, implementation and evaluation of protocols?**

There was no evidence of families participating in drafting protocols and policy. However, the involvement of people using services is generally agreed to be an area worthy of much more attention.

### **Are there locally agreed guidelines for joint management and supervision of complex cases involving more than one service?**

There are formal systems for managing complex cases including joint protocols and multi-agency panels, as well as informal mechanisms whereby senior staff provide advice and guidance.

### **Are the respective departmental eligibility criteria and service thresholds clear and agreed?**

There were no examples found of specific criteria for eligibility for services based on a parent with a mental health problem having responsibility for a child. Nor were there any services operating a 'family' threshold (i.e. one which took into account the combined needs of parents, carers and children).

*In AMH services:* an initial assessment is offered to all and entry to the system depends on a mixture of clinical judgement, risk and availability of services. Eligibility depends on whether the person has severe and/or enduring mental health problems.

*In C&F services:* the potential risk of harm or being a **child in need** prompts assessment. Parental ill health does not by itself qualify a family for services.

*In CAMH services:* children need to show signs of emotional or mental health difficulties to be eligible for services.

## **Access to services**

### **Are families with parental mental health problems able to access appropriate support for the parent/child?**

People who use these services have reported problems with accessing appropriate support. The main concern is that access is often limited to times of crisis. Poor

communication, poor recording of information, high staff turnover and a lack of worker knowledge often make these problems worse.

Some parents are concerned about the stigma attached to AMH services and/or C&F services. Their fear of having their child taken away may also make them reluctant to discuss their problems and access the services they need.

Sometimes a 'don't ask, don't tell' approach is adopted. This is partly due to the assumption that other agencies/services are assessing needs and risks.

### **Do the 'usual' service eligibility criteria impede access for such families?**

There are problems with eligibility criteria where:

- Service users have to meet the eligibility criteria of each individual service: the way that a person's different needs interact with and compound each other is not taken into account.
- Families may meet the criteria for one agency, for example, C&F services, but if threshold criteria for other services such as AMH are not met, a single agency may struggle to provide enough support on their own.
- Thresholds for support are based on risk and the criteria used by adult services can be very different to those used by children's services.
- A common language is not being used across agencies, which can lead to both lengthy delays in referrals and inappropriate referrals being made – the criteria in one agency are often unclear and unintelligible to others.
- The criteria can be very rigid and people fall through the gaps.
- There are no formal structures to resolve issues.

There are also concerns about families who are below threshold criteria for specialist services. It is unclear whether the general services available to those who only need a little extra help, actually meet the specific needs of families with parental mental illness.

### **How do managers/practitioners respond when a service is needed, but the parent or child do not meet the eligibility criteria or threshold for services?**

Staff and managers attempt to be flexible and 'get round' eligibility criteria by:

- trying to be pragmatic and using the joint protocol as a way of thinking outside the box
- holding monthly meetings of a joint interest group to try to resolve the issues
- convening multi-agency meetings
- using the Care Programme Approach (CPA)
- adopting the 'team around the child' approach.

### **Are there any special issues in relation to access for BME families?**

BME people using these services report that they have more difficulty in accessing AMH services, but no hard evidence for this was found.

Some staff believe there are no significant difficulties for BME users accessing services. Others have concerns that because workers are predominantly white, there may be cultural and language barriers that make access difficult.

Some staff are particularly aware of the needs of BME parents and are committed to confront discrimination in all their work. Others feel that, generally, workers have a limited understanding of different cultural needs. The view of BME people using these services is that staff do not always acknowledge their own prejudices.

A study of BME families known to C&F services showed that they are over-represented on child protection registers and in serious case reviews, but under-represented in supervision discussions with health visitors. One interpretation is that staff accept a family's assertion that worrying childcare practices are 'cultural', and it is not until crisis point that someone challenges this assertion.

### **Are there any special issues in relation to access for refugee and asylum-seeking families?**

Asylum-seeking families are thought to experience more difficulty in accessing services, but again no hard evidence was found to support this.

The main barriers to access are considered to be language difficulties, lack of extended family, lack of knowledge about possible services, poverty, and no recourse to public funds.

## **Information for people using services**

### **Is information freely available to adults and children in accessible formats on the following topics?**

- understanding mental illness
- signposting to other services
- being a young carer
- range of treatments and services available
- understanding the direct and indirect impacts of mental health problems on parenting, parent-child relationships and children.

Information is most readily available on understanding mental illness and the range of services and treatments available. Signposting information tends to be less readily available. It is often the people using these services themselves who collect information and inform staff of other services and resources.

Information is usually provided via locally produced leaflets, mental health trust or social services websites, or third-party websites/leaflets, from the Royal College of Psychiatrists, for example. Although some agencies' websites are high quality and

well developed, there are still problems because staff do not always know what the websites provide and some people using services are unable to access the internet.

People using services also comment on the lack of information in languages other than English and a lack of information about user experience.

Staff frequently comment that discussion may be more effective than providing printed material, or that they should aim to provide individualised information. However, there is little consensus as to which service should take responsibility for this, with each service believing that others should take on this role.

## **Assessment and care plans**

### **Do assessments routinely check and take account of the family context?**

Assessments rarely take account of the whole family context. People using services have commented that assessments are 'partial' because they are too fragmented and 'only the service user holds the whole picture'.

C&F staff do not routinely assess parental mental health. While some C&F services have mechanisms in place to ensure this happens, others depend on the initiative of individual workers.

Within AMH services, behavioural family therapy appears to be the only reported therapeutic intervention that involves 'whole' families, including children. AMH staff do not routinely assess if an adult using these services has children. Nor do they routinely assess the risks for any children, or offer any therapeutic interventions for family members. While the CPA should ensure that the family context is considered, it tends to focus more on individual pathology, signs and symptoms, rather than on family responsibilities and the social context of patients' lives.

There is also a general lack of awareness and understanding of the needs of young carers.

### **How are assessments of parenting capacity made when parents have a mental health problem?**

Assessing the impact of mental illness on parenting is often a challenge for staff from all disciplines. There is still a silo mentality and sometimes the attitude of 'it's not my responsibility' prevails.

For C&F staff the problem is a limited knowledge of mental illness, particularly its impact on parenting. Nor do they often consider that parenting will have an impact on a person's mental health. Their fear of mental illness means they tend to defer to AMH staff to make assessments about parenting capacity. However, AMH staff are also reluctant to make judgements about the impact of mental illness on parenting because they lack familiarity with child development.

Tensions often arise when staff from different disciplines adopt different views, for example, when AMH staff seem unwilling to acknowledge there is a risk to children and C&F staff appear not to accept that change might be possible for the parent.

The concept of resilience is also not generally well understood. This means that assessments rarely explore a family's strengths in the same amount of detail as any areas of concern. As a result, action plans typically fail to promote the resilience of either the parent or the child. In the absence of preventative measures and forward planning, families can 'drift' until crisis point is reached. The routine process of assessment and case management tends to take over, rather than paying attention to the families' current needs or how best to maintain the family when things are going well.

### **How do agencies work together to support the whole family?**

The general impression is that inter-agency work is clear and purposeful when concern is high. However, when thresholds are not met and concern is low, sharing information and carrying out joint-care assessments and planning is much less likely to happen.

Successful collaboration seems to depend on the personalities, skills and confidence of the individuals involved. It works well when staff are committed, adopt a holistic approach to the needs of those people using these services and take responsibility for managing risk. However, there isn't a system-level approach to ensure that agencies work together or to ensure that their separate assessment and planning processes take into account the whole family and their interconnected needs.

Often when staff from different disciplines work together, they work in parallel rather than collaboratively. Because they frequently lack sufficient understanding of other professionals' roles, they may not gather or share the information that their counterparts need. Their differing perspectives may also make it difficult to reach consensus on decisions.

Strict entry criteria and service boundaries do not allow practitioners to feel able to collaborate or undertake joint working arrangements across service settings. There can also be disagreements as to where responsibilities lie. For example, AMH tend not to arrange home support for children when a parent requires treatment, because C&F services are viewed as being responsible for all forms of child support.

AMH service staff can find child protection work particularly challenging. They may be reluctant to get involved because:

- their focus is on the adult and encouraging their clients to accept medication/health advice
- they may fear damaging working relationships with their clients
- they tend to adopt an advocacy role in respect of the parent
- they may not recognise that there are underlying parenting difficulties in addition to mental ill health
- they may not understand the needs of the child or child protection issues

- they may find it difficult to assess risk and be slow to identify or share concerns about risk.

### **What is the role of the child protection coordinator in promoting inter-agency work?**

Child protection coordinators (CPCs) can play an important role in promoting inter-agency collaboration, particularly at child protection conferences and core group meetings by:

- facilitating the assessment process, for example, by identifying gaps in the information and asking relevant questions
- negotiating and brokering arrangements outside the formal meeting process
- maintaining a focus on child safety and helping agencies to develop common goals and shared responsibilities
- ensuring protection plans are multi-agency
- encouraging and supporting the involvement of AMH staff
- providing advice and problem-solving in collaborative work.

The challenges for CPCs in this role are:

- assessing how a specific mental health problem impacts on parenting: consultants usually help with this but rarely attend CP conferences
- lack of support from their organisation: supervisors rarely understand mental health issues and innovation tends to be favoured over and above consistency and development of existing service provision
- keeping up to date with all areas of research and legislation.

However, it may be unrealistic to expect CPCs to be experts in all areas. A more effective strategy might be to help them create and facilitate a network in which knowledge can be shared easily between different professionals and partner agencies.

### **How is communication maintained between relevant people/agencies with regard to changes in treatment, plans to discharge etc?**

Communication is easier and more likely to be maintained when the patient's illness means that formal planning processes such as CPA and CP are required. It becomes more difficult when families are below threshold criteria.

### **Do 'CPA crisis plans and contingency plans' explicitly refer to issues relating to parenting and childcare in the event of crises?**

There seems to be no problem with CPA crisis plans identifying and dealing with parenting and childcare problems. AMH workers attend CP conferences and review meetings and staff are familiar with the assessment framework guidance.

### **Are there any issues about resources and funding for joint-care packages?**

Funding joint-care packages remains an issue. For example, C&F staff sometimes expect AMH staff to set up simple services, such as collecting from school, while AMH staff do not see this as their responsibility.

**Are disagreements between adult mental health and child welfare services effectively resolved and how does this happen?**

Disagreements between services are mainly concerned with who will pay for which service component. These disputes are resolved by managers who debate their interpretation of joint protocols, thresholds and procedures. This can become a significant element of managers' work, with sometimes very senior managers getting involved. This begs the question whether or not this is a good use of management time. Front-line staff do not appear to have much delegated decision-making powers in resolving funding disputes, but this may also be poor use of their knowledge and skills.

**How do supervisors/managers ensure that they have a comprehensive overview of the whole family's needs and how they impact on one another?**

Generally, managers and supervisors do not have access to a 'whole family' overview.

**What policy/guidance/procedures support the involvement of young people and other family members in decision-making processes regarding care and support?**

One example was found of where young carers are highlighted in the local children's strategy, carers' strategy and CAMH's strategy. As a result, specialist mental health services in the area have established practices for identifying and assessing both parents and young carers through a system called enhanced care coordination. This also enables young carers to influence the care plan for their parents. This development is largely due to the championship role of the local voluntary sector.

More generally, it seems that the views of young people are not taken directly into account when making decisions about the care and support of family members. It is rare for their opinions even to be sought. Similarly, young carers' assessments are not routinely fed into adults' care plans because a number of barriers still exist.

Links with other family members are part of the enhanced CPA and may be required in local protocols. However, whether these links are made in practice depends on the approach of the individual worker.

**What support – including information – is available for young carers caring for a parent with mental health problems?**

Local Young Carers projects are the key resource for young carers.

**Managing separation when a parent is in hospital**

**Is there local policy on children visiting psychiatric wards?**

There are concerns that psychiatric hospitals can be distressing places for children. Visits by family members are treated very differently to visits to general hospital. This reflects government guidance, the nature of the illness and the hospital, but also the shame, stigma and uncertainty that surrounds mental illness.

Although there are often clear policies to enable children to visit psychiatric wards, practical problems remain, including the availability of suitable rooms and ensuring appropriate care and supervision of the children.

### **How is contact between parent and child managed and supported when the parent is in hospital?**

Contact between parent and child is managed and supported in various ways (some more proactive than others) including:

- admission staff discuss this issue with the patient
- care coordinators in AMH take on this responsibility
- leaflets are provided to patients which explain that such visits are part of the patient's nursing plan
- the approved social worker takes on this responsibility in making emergency applications.

When a child is in foster care and the parent is in hospital, C&F services are responsible for helping children maintain parental contact.

The difficulties that are encountered include:

- timing and practical arrangements, such as who will do the taking, collecting and supervising
- dealing with the child's embarrassment and/or unwillingness to visit their parent
- ensuring a safe environment
- finding foster parents who are willing and skilled at dealing with parental mental illness.

### **Managing separation when a child is in local authority care**

#### **How is the right of the child to direct contact with both parents on a regular basis respected in reviewing processes?**

Contact is at the heart of the child looked after (CLA) process and is recognised as being essential to maintaining a relationship between the child and their parent. Making decisions about contact and ensuring the arrangements work depends on good-quality inter-agency working relationships, clear communication and a willingness on the part of all to be flexible and accommodating. This is an area that would benefit from clear guidance.

Some foster carers are resistant and lack confidence in dealing with mentally ill parents. This raises questions about the role of the supervising social worker and the training offered to foster carers, which is felt to be minimal in the area of parental mental health.

Independent reviewing officers (IROs) play an important role here because they can:

- challenge staff thinking about contact, particularly assumptions about contact being unhelpful for the child
- check the child has been given accurate information about their parent's difficulties and that the child's fears about becoming ill themselves have been addressed
- check foster carer's views about the parent's mental illness and encourage them to de-stigmatise mental illness for the child.

### **How are the perspectives of parents, children, foster carers and key professionals brought together in the review of looked after children?**

It is a Department for Education and Skills (DfES) requirement that consultation documents are sent to the child, parent and foster carer/residential unit in advance of the CLA review, with the expectation that issues are flagged up before the meeting. There is no formal pre-meeting consultation of staff from other agencies.

Information is gathered from all involved parties, either face to face, in writing or by phone/email or text. This information is used to inform decision-making. Many of the key decisions are made in advance of meetings, involving parents to varying degrees, and then only ratified at the review. There is some resistance to the idea of parental advocates being at the meetings themselves.

### **How do agencies work together in the CLA review process?**

There are some examples of good practice in inter-agency working, for example, joint visits and assessments and provision of coordinated support to parents. However, more frequently there is not enough liaison between AMH and C&F staff in relation to continuing assessments and care plans.

CPNs are encouraged to maintain contact with the C&F worker. They are also invited to CLA meetings, but may resist attending what are seen as 'duplicate' reviewing processes – CPC and CLA reviews.

C&F staff can also be invited to attend CPA meetings. This can be resisted by AMH staff because of parents' requests for confidentiality to be maintained.

In the review meetings, there is often tension because of conflict between the rights of parents and children. This can make information sharing difficult. When this happens, the Chair/IRO will make information sharing a formal recommendation.

## **How is contact and information exchange managed between parent and child?**

Contact arrangements are considered at every statutory review, and if there are any significant issues in relation to contact, or changes since the last review, the IRO can be consulted in between reviews. Review meetings can be brought forward if significant changes need to be discussed and agreed.

IROs can make sure that parents attend reviews if this is important for the child. At the same time, they have to think about the best way to manage the process and ensure it is in the best interests of the child.

IROs can also recommend flexible contact arrangements in response to parents' needs. For example, parents with fluctuating mental illness may need contact more frequently when they are well, but only indirect contact when they are unwell.

The review process works well and achieves the goal of consistent and effective contact and information exchange when:

- local authorities have policies of mandatory attendance at review meetings
- all stakeholders are consulted and relevant pre-meetings take place
- the agenda is agreed in advance
- there is a family strategy, which champions a family model of parental mental health
- problems are anticipated and formal decisions are made about responsibilities, for example, for communication.

Responsibility for maintaining communication appears to rest, often by default, with the child's social worker. Ward staff will contact the child's social worker and in the absence of a proactive parent, the social worker will make arrangements for contact.

## **What are the issues in maintaining contact between parent and child and receiving information about family members?**

It is important to give the child clear information about their parent's mental health but this needs to be appropriate to their age and understanding. Where the child is placed with foster carers there needs to be an adequate sharing of information to enable them to care for the child and help them support contact with the child.

The situation becomes more complicated when the child is accommodated and placed with a family member who may be in conflict with the parent. This can make it difficult to openly share information.

There may also be conflicts between the child's wishes and parents' wishes, for example, if children ask that their decision to withdraw from contact is not discussed in front of the parent. Staff need to judge the importance of honesty versus providing support.

Thus there may be many issues that need to be addressed outside the CLA review meeting.

### **How do agencies respond to changes in the parent's condition?**

IROs can identify where children are coming in and out of Section 20 care because of a parent's fluctuating mental state and lack of stability, and where there seems to be a lack of overall planning, they can recommend a legal planning meeting.

However, supervising and supporting contact in the long term can be a problem. Foster carers can be left making decisions about whether contact arrangements are appropriate and change them if necessary. The IRO should recommend and check that decisions are not left to carers and that C&F services involve AMH staff in decisions about contact.

### **How is the impact of separation on children and parents with a mental health problem assessed over time?**

This kind of holistic assessment rarely happens because the focus of the proceedings is always on the child. The parent's mental health and prognosis is considered as part of the 'business' of CLA review meetings, particularly when reviewing contact arrangements. However, it is not given a high priority and becomes less of an issue the longer a child has been looked after.

It seems that following the routine steps of the process of the review dominates proceedings, rather than addressing the family's current and actual needs.

### **How is communication maintained between relevant people/agencies regarding any changes in the child's care plan or plans to discharge from care?**

This is a problem area because there is no requirement to have core group/professionals' meetings between reviews, and communication is poor. What usually happens is that the Chair of the review has to anticipate all eventualities and plan for them.

When children are discharged from care the IRO can attend the child protection conference or family support meeting to ensure continuity between the care plan and safeguarding/child-in-need plans. But there is no statutory requirement to do this.

The IRO should make sure that:

- the parent, and relevant AMH staff are invited to/involved in the review process if there are any proposed changes in the child's care plan
- any changes in the care plan or plans to discharge from care are included in the planning for the parent and considered in the CPA plan
- the child's social worker maintains contact with AMH staff in the long term, to make sure that any significant changes in the plans for the parent are known to those responsible for the child's care plan.

## **Information systems and information sharing**

### **Are teams and workers clear about appropriate information exchange?**

Information sharing seems to work well in some areas, particularly when professionals have established good working relationships. However, information sharing protocols are often unclear. It can also be especially difficult to share information outside of health/social care, for example with education services or the voluntary sector.

Even when policies are clear and agreed between agencies, staff often remain confused about what information can be shared and with whom. Training can help to improve this.

There are also a number of concerns related to information sharing, including:

- There are more difficulties in the 'grey areas' – staff are clearer about information sharing in situations of 'crisis/extreme need'.
- GPs play a key role in providing information but often lack capacity or are reluctant to do so.
- Different professional groups may have different grounds for sharing information, use a different language and lack sufficient understanding of each other's roles to share the right information. AMH staff also have concerns about confidentiality.
- AMH staff are concerned that C&F staff may make important decisions based on limited information such as diagnosis, or over- or underreact because they do not have a good understanding of mental illness and risk. C&F staff report that it is sometimes difficult to get reliable information from their AMH colleagues.
- The people using these services do not always support information sharing. Although they accept that information may need to be shared 'during periods of acute distress', they believe that their views should be taken into account when they are well. However, 'this distinction is not always adhered to'.

### **Are intra-and inter-agency information systems compatible?**

Current data collection systems may not be providing all agencies with appropriate and relevant information. Systems need to be developed to enable collection of relevant, timely and meaningful data to support service provision and planning.

There were no examples found of information systems that are compatible across agency boundaries.

### **What is the system for checking if someone is known to services and what their status is?**

There does not appear to be any routine system for checking the status of people using services. The responsibility lies with individual workers. The potential to use IT systems for this purpose has not yet been fully developed.

### **How useful are reports and risk assessments from different agencies?**

The quality of reports is variable. Some reports are very good and demonstrate that the worker has really understood the issues, the impact on the child and what needs to change, and has also helped the parent to understand the concerns.

Family Centre reports are particularly good at addressing both child and parental needs and the impact on parenting. These are the staff most likely to recognise the symbiotic nature of mental health and parenting.

Other reports can be poor quality and limited in detail. Common concerns are:

- They tend to focus on key incidents, such as admission or relapse, rather than the factors leading up to an incident or the subsequent impact on either the parent or the child. This makes it difficult to identify appropriate interventions.
- They can contain inaccuracies regarding diagnosis or medication. This information may be perpetuated in records because 'labels stick'. This makes it difficult to address people's genuine and individual needs.
- Sometimes workers avoid presenting the full information in reports as they worry that this will impact on the parent's mental health.
- Little information is provided when parents have mental health problems which are not easily categorised or where there is no diagnosis.

### **Managing the care pathway across services**

#### **Is there a forum for front-line managers and supervisors to share views and discuss service and practice improvements and changes?**

In general, staff rely on more informal ways of exchanging ideas including:

- training
- crossover posts
- safeguarding boards
- home treatment forums
- team treatment forums
- team manager forums.

#### **What are the issues for managers and supervisors?**

Some of the issues for managers and supervisors include:

- communication between services
- training
- funding
- developing a family strategy
- capacity and thresholds

- transitions
- poor access to AMH compounded by poor access to primary care
- lack of understanding of mental illness by C&F services
- lack of understanding of families' needs by AMH staff
- no systematic joint work.

Most of these issues relate to individual cases and often remain unresolved. Because a strategic approach is not always adopted, strategic solutions are not being sought or found.

### 3. Local service developments

#### **Capacity developments**

##### **Which staff represent the needs of parents with mental health problems and their children?**

There is no single professional group representing the needs of parents with mental health problems and their children. As there is no common understanding of who does or who should lead on this issue, it is difficult for any professional to be clear about their role or contribution.

AMH staff highlight the importance of links between child protection and domestic violence and vulnerable adult services as well as parental mental health. There are concerns that no one represents children in these other service areas.

GPs recognise that they could give more thought to parenting issues when treating patients, but tend to be focused on getting the right treatment started. Their level of engagement depends on the individual GP's level of interest. Some do not believe they have a role in either mental health or child development, seeing this as the responsibility of other professionals. Others take a more holistic approach and offer family therapy through their surgery, for example.

##### **Has there been any specific recruitment of staff or other capacity developments to address the needs of parents with mental health issues? Have these been evaluated?**

Some specialist posts have been created to focus on this area of practice, for example, a part-time AMH worker in a Sure Start children's centre and C&F senior practitioner posts in AMH. Staff in existing roles have also taken on some responsibility for this area of work.

There has been very little evaluation of the impact of these new roles or capacity developments. One example was found where the impact of specialist workers on the daily lives of parents and their children had been evaluated. This evaluation found that – from the perspective of those people using services – specialist staff provide 'a clear and readily available source of support from people who do not critically judge or respond to their thoughts, feelings or behaviours in an overly

anxious way'. The service had helped users to form and maintain contact with mainstream AMH and C&F services.

## Training

### **What skills, knowledge and attitudes are needed to provide effective leadership and management of staff in cases where there is parental mental health and child welfare?**

Managers in C&F, AMH and CAMH services need to understand:

- the inter-related nature of mental health difficulties, parenting and child development
- a 'family model'
- all parts of the professional network.

While they may not be able to maintain a comprehensive, up-to-date knowledge of all relevant topics, they would be helped by:

- strong working relationships across divisions, particularly at senior management level
- a culture of respect for staff in different disciplines.

### **What training and development opportunities are provided to staff to ensure they have the necessary knowledge, skills and attitudes?**

Examples of workforce developments include:

- joint training for AMH and C&F staff
- courses for C&F staff on mental health issues
- workshops for managers to disseminate learning to staff after every serious case review
- mandatory child protection training for AMH staff.

Training was identified as a key concern for both AMH and C&F staff. There appears to be a substantial unmet need for training – particularly joint training in this area.

### **What qualifying and post-qualifying training would help people to acquire the skills, knowledge and attitudes needed?**

- Regular post-qualifying training events could usefully include:
  - multi-agency events which champion collaborative working and demystify the work of staff in other disciplines (a problem caused by early or over specialisation)
  - single-agency events which remind senior practitioners of the need to seek information from colleagues from other disciplines, as well as empowering them to challenge others when this is in the interests of their client group.

- Training on a family model of parental mental health (including the impact of parental mental health on children) to ensure it is understood by all practitioners and also centrally embedded in the culture of organisations. This could be part of undergraduate and nursing training.
- Communication skills training at college and in student placements.
- Training in talking to and working with children for all staff including AMH staff.
- Child protection training as a core component of basic professional training rather than offering it as a 'bolt on' to experienced staff.
- Wellbeing and child welfare training – not only child protection and safeguarding training.
- Training in providing support and communication with parents with personality disorder.
- Training in cultural differences and sensitivities.
- Shadowing/placements with staff in other disciplines.

*What other initiatives could help improve practice in this area?*

Ideas for improving practice include:

- Local Safeguarding Children Boards (LCSBs) developing protocols and monitoring adherence to protocols
- developing clear mandatory guidance
- motivating middle managers to develop new collaborative initiatives that are monitored and regularly scrutinised
- mandatory directives for cooperation/joint arrangements between AMH and local authority services
- cross-discipline, jointly funded and managed posts
- AMH directors sitting on LSCBs
- motivating staff to think about the needs of families by developing performance indicators in this area, for example, monitoring inclusion of children and parents in case assessments as part of the CPA and the Common Assessment Framework (CAF).

## **Collaborative/inter-agency developments**

**What inter-agency developments would you like to see?**

Ideas for inter-agency developments include:

- improved information sharing systems with better access to information for AMH and CAMH staff
- access to other organisations' databases for commissioning purposes

- ability to approach managers from other services areas when necessary, for example, arrangements on discharge from hospital
- better understanding of other staff's roles and greater flexibility around roles – could be addressed through induction/shadowing/secondments
- effective strategies for working with parents 'to help their children understand parental mental health'
- use of extended schools for providing services for parents with mental illnesses and their children
- AMH involvement in the development of the CAF
- joint linking between AMH and C&F in meeting their social exclusion agendas and targets
- a focus on improving access to primary care mental health services, and family systemic interventions at tier-one level
- joint-strategy development regarding adults and children and young people's services that brings in cross-over issues of housing, access to education and employment, and family wellbeing
- identification of 'champions' in each service who would provide a focus for consultation, advice and support and propagate improvements in the service
- developing centrally agreed protocols as well as rigorous systems for monitoring their implementation
- regular auditing of both the quantity and quality of collaborative work.

## 4. National development

### **Policy/guidance development**

#### **What would you like to see included in national guidelines on parental mental health and child welfare?**

There is a lot of support for developing national guidelines. Some managers/authorities feel they have to develop services in isolation and could do with more guidance and leadership.

There is also a strongly held view that national government is not leading on this issue. The lack of a family perspective in central directives makes it difficult to make progress in this area at the same time as delivering other government imperatives.

Ideas for what topics need to be included in national guidelines include:

- links with other national initiatives, for example, the social exclusion agenda (extended schools), CAF
- a clear definition of the term 'mental health problem' that is useful to all services
- confidentiality and data protection issues
- better primary care

- more user involvement in developing and delivering services
- better information about the services available
- better information for children
- a requirement for adult services' practitioners to work with all family members to share information and educate them about the parent's illness
- developing and implementing a family strategy in all sectors including private providers
- more input from AMH into children's services and vice versa
- joint working at front-line and strategic levels
- more input from schools
- agreed thresholds and clear service triggers
- more commissioning from third-sector providers
- better feedback loops
- tackling the stigma and fear of parents seeking help
- more service developments for BME and asylum-seeking families and improving access for these groups
- more support for parents on discharge and more consideration of multi-faceted problems, for example, the association of mental ill health with domestic violence, alcohol and illegal substances.
- more low-level support and preventive work
- configuration and/or development of 'joint' services – especially in relation to assessment and early identification of the need for support
- standardised assessment tools that include parent, child and family needs
- standardised tools that should be used nationally to collate information, for example, screening tools (referral forms that indicate information regarding children/dob/school)
- ongoing assessments for young carers that encourage young people to share information and develop a relationship of trust with services
- addressing young carers' needs separately from adult carers.

## Context

The findings in this report is being used to develop SCIE's guide to parental mental health and child welfare<sup>2</sup>.

## Acknowledgements

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