social care
institute for excellence

At a glance **55**

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# Think child, think parent, think family: Putting it into practice

### Key messages

- Parents with mental health problems and their children need services that are effective and accessible for the family.
- Getting it right for families is hard given workloads and organisational barriers, but can help tackle problems now and across generations.
- Implementation sites in England and Northern Ireland have developed promising ways to 'think family' and improve services as a result.
- By raising awareness, developing strategic goals, training staff and tackling stigma, sites have created the conditions for think family working to flourish.
- By thinking family throughout the care pathway, individual staff can make small but effective changes for parents and children.
- Further work in this area could produce further improvements, even in challenging times.

## Introduction

Meeting the needs of parents with mental health problems and their families raises practical, professional and organisational challenges for services. SCIE's guide, *Think child, think parent, think family* (2009, revised 2011) addresses these challenges, and recommends ways to overcome them. To test these recommendations, SCIE supported the implementation of the original guide in five English local authority areas (Birmingham, Lewisham, Liverpool, North Somerset and Southwark), and all five Northern Ireland health and social care trusts. From September 2009 to September 2011 in the English sites, and from September 2009 to March 2012 in Northern Ireland, SCIE staff supported the sites to develop whole-family working in line with the guide's key recommendations. SCIE has produced interim and final evaluation reports and this At a glance briefing summarises what the implementation sites did, and the lessons learned.

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## The importance of whole-family working

Parents with mental health problems and their children often have complex needs. Families won't always need health and social care services, but those that do often struggle to get accessible and effective support that addresses children's needs and also recognises the parental responsibilities of many adults with mental health problems. Research and government reports

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highlight the numbers involved, and the potential intergenerational impact:

- In a class of 26 primary school children, six or seven will live with a mother with mental health problems.
- The 2001 census identified 29 per cent of young carers – just over 50,000 children – as caring for a family member with mental health problems.
- One in four to one in five adults will experience a mental illness during their lifetime, and at the time of their illness, a quarter to a half of these will be parents.
- Parental mental illness can adversely affect child mental health and development, while child psychological and psychiatric disorders and the stress of parenting can have a negative impact on adult mental health.
- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves.

Adult mental health and children's services need to work together to meet the needs of families. However, current organisational structures are complex. Mental health and children's services have different legal frameworks, policy and practice. This has led to the specialisation of knowledge and skills within the different departments. Specialisation has its benefits, such as in-depth experience in one area, but it can also limit the 'breadth of view' of some professionals and organisations.

Managers and practitioners also report that the lack of a family perspective in policy and performance indicators makes progress difficult in this area.

Working in either adult mental health or children's social care services can be sensitive and controversial – attracting media attention and sometimes criticism – and staff can be wary of stepping outside professional boundaries. As important as breaking down these professional barriers is tackling the stigma attached to accessing services for parents with mental health problems and their children.

## What the sites did

SCIE's guide features key recommendations to promote whole-family working, including ways to think family – considering the needs of the adult as a parent, the child, and the whole family at the same time – throughout the care pathway, and strategic work to support this approach. Only Northern Ireland had the resources to implement each recommendation systematically. Each English site used a steering group to decide which of the guide's recommendations to focus on – depending on local needs – and drew up implementation plans accordingly. Most activities were aimed at families known to statutory services, but not at the highest tiers of either adult mental health or children's services. Here we look at highlights from the huge amount of work undertaken.

## Strategic approaches

The sites provided strategic direction to the implementation in various ways:

- think family strategies, setting out improvement priorities for local services for parents with mental health problems

> The sites provided strategic direction in communications strategies to raise awareness of family issues and address the stigma of mental illness.

- including whole-family principles in general strategies, like the Children and Young People's Plan
- protocols outlining how adult mental health, Child and Adolescent Mental Health Service (CAMHS), children's social care and the voluntary sector should support families together (Northern Ireland's protocol was wider in scope, bringing in services such as A&E and maternity care)
- communications strategies to raise awareness of family issues and address the stigma surrounding parental mental illness
- Northern Ireland developed performance indicators for measuring whole-family outcomes
- in North Somerset, thinking family helped shape a restructure called Total Family, which looked at possible savings from better coordinated, earlier interventions.

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## Involving people who use services

Working with parents and children is pivotal to the guide, and the sites engaged users in the implementation in various ways:

- Lewisham established a parents' group to advise on the project, and offered mutual support. Some group members went on to address senior policy-makers with their perspective.
- Parents in Southwark made a film of their experiences of services and how to improve them.
- A survey was conducted in Northern Ireland on the views of parents with mental illness.

People who use services – or their representatives – added an enthusiasm to the steering groups, and a reality check when professionals became too involved in policies and procedures.

Hearing personal perspectives also reminded groups about the relevance of their work.

## Workforce development

All the sites took actions to develop staff knowledge and skills, from awareness-raising events through to in-depth think family learning. In Northern Ireland, a knowledge and skills framework was developed, covering five practice 'domains':

- promoting wellbeing
- communication
- safe and effective care
- signposting/improving access to services
- intervention.

Some sites, notably Birmingham, added think family modules to existing safeguarding or induction courses; others commissioned bespoke training, such as a theatre group dramatising dilemmas of whole-family working. Liverpool ran 'lunchtime learning' slots to introduce think family principles to multi-agency staff, and Southwark trained mental health staff in the Family Partnership Model.

### Champions' group

North Somerset developed a champions' group involving practitioners from across children's services, and primary and secondary adult mental health. The group raised awareness and mutual understanding, discussed specific cases, acted as think family specialists within their own teams, and worked collaboratively on cases. The group was effective in breaking down barriers, and its success was reflected in the model being introduced in other sites.

## Thinking family throughout the care pathway

Key to the guide's recommendations is thinking family throughout the care pathway, from promoting awareness, accepting referrals, assessing needs, and planning, providing and reviewing care. Important work undertaken by the sites included:

- posters to promote awareness of parental mental health and its impact on young carers
- updating Child in Need risk screens to show the mental health needs of people in parenting roles
- adapting assessments to take the whole family into account
- locating adult mental health staff in children's services, and child specialists in mental health teams, to encourage joint working
- piloting easier routes to the children's Common Assessment Framework (CAF) system for adult mental health staff
- identifying trigger levels for contacting other services
- therapeutic group work for fathers, and mothers and toddlers.

## Lessons about process

In England in particular, rather than implementing new activities, sites integrated think family approaches into existing documents and practices. This was partly a response to busy working environments – which left limited time for undertaking substantial stand-alone projects – but was also a direct strategy to achieve immediate impact. To succeed, different initiatives needed to complement each other, and integrating think family approaches in different policies and workstreams may help to ensure its longevity during a time of change.

The regional mandate in Northern Ireland, supported by two full-time workers, meant that strategic, region-wide documents – such as the Knowledge and Skills Framework and multi-disciplinary working agreement – were more readily achievable, and served to promote consistency across the country.

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In both England and Northern Ireland, significant factors in helping or hindering progress were:

- Competing pressures – improving services, particularly in a period of resource constraints – was challenging because of people's overflowing schedules and conflicting demands.
- Senior support – the active backing of senior staff with an enthusiasm for this agenda was probably the most important factor determining whether sites made concrete changes to working practices.
- Organisational and professional attitudes to change – people's willingness to view their remit flexibly made a real difference to what could be achieved.
- Time to build relationships – in sites with a history of multi-agency working, key relationships were already in place. Elsewhere, some steering group members were meeting for the first time, so early meetings were spent learning about each other's roles, and building relationships and trust.
- Resources – many difficulties, such as the lack of knowledge and understanding of other professionals' roles, cannot necessarily be solved by more money. The broader financial climate did though negatively affect the

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capacity of sites to implement this agenda, as specific grants were cut, and redundancies meant those remaining in post had even greater workloads.

- Administrative and project management support – to coordinate work and ensure tasks were completed.

## Lessons about practice

The sites developed several promising approaches to practice. Joining the project to initiatives for young carers, general parenting, and substance misusing parents created practical links and avoided duplicated efforts. Developing partnerships with, and capacity in, the voluntary sector created opportunities for families to access support away from the high eligibility thresholds in the statutory sector.

Across the English sites, both the Common Assessment Framework (CAF) and Team Around the Child (TAC) seemed to help people think family. The CAF – an assessment process that is in many places the mechanism for referring children whose needs don't meet the criteria for statutory services – seemed to encourage staff to consider the needs of both parents and children when assessing and planning care. TAC is a process for supporting children with additional needs, where all the professionals involved with a child's care meet regularly to coordinate that care. Several sites sought to expand this to a Team Around the Family, also including professionals working with the parent.

Other encouraging developments included:

- harmonising screening questions across agencies to improve inter-agency referrals and signposting
- improving young carers' access to services
- hosting inter-agency complex case discussions
- liaison workers between adult mental health and children's services.

## Remaining challenges

A number of issues remained partially or largely unresolved as the project ended, and these would benefit from further investigation. Involving children directly in project planning was sometimes hampered by practicalities like school attendance and parental reluctance for their children to engage with services, perhaps due to stigma and fear. This project included some promising exploration of the potential for the CAF to be used to support integrated working, but there was less exploration of the possibilities offered by the Care Programme Approach (CPA) used in mental health services. Nor were family service thresholds explored as a means of promoting earlier interventions.

Information sharing at a strategic and case-specific level remained problematic, despite some advances in Birmingham in triggering inter-agency liaison. Technical solutions are needed to facilitate joint working on individual cases and gathering population-level information on numbers and outcomes.

Barriers to developing meaningful outcome indicators for families affected by parental mental ill health also remain. The increasing emphasis on localism could mean that local sites and regions may have more flexibility to work on this now than previously.

The focus on improving joint-working between key health and social care departments often contributed to less engagement with GPs and

schools. As universal services without the stigma of adult mental health or children's social care, GPs and schools could play a vital role in addressing the effects of parental mental illness.

Drawing on the Northern Irish experience, national-level liaison with higher education institutions in England could be a fruitful way to ensure that think family principles are embedded in professional education.

## A note on terminology

The terms 'Think child, think parent, think family' and the shorthand 'think family' and 'think family approach' are used interchangeably in SCIE's work.

## Further information

SCIE guide 30: *Think child, think parent, think family: a guide to parental mental health and child welfare*.

SCIE report 44: *Think child, think parent, think family: interim evaluation report*.

SCIE report 56: *Think child, think parent, think family: final evaluation report*.

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Meltzer, H., Gatward, R., Goodman, R., and Ford, T. (2000) *Mental health of children and adolescents in Great Britain*, London: The Stationery Office.

Social Exclusion Taskforce (2007) *Reaching out: think family*, London: Cabinet Office.

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