Parental mental health and child welfare: reviews of policy and professional education

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Chapter 1: Introduction to the Reviews

1.1   Aims of the Reviews

These knowledge reviews contribute to a larger SCIE review. Action 16 of the Social Exclusion Unit report, *Mental Health and Social Exclusion*[41] directed SCIE to work with the National Clinical Institute for Excellence (NICE) to review existing knowledge and practice in health and social care services regarding parental mental health and child welfare. New guidelines for health and social care staff working with adults and children in a range of settings will be produced. The SCIE/NICE review is comprised of three phases, the first of which is a series of interrelated knowledge reviews– this report is one of those. It presents the results of searches of policy and searches of guidance on professional education, to ascertain whether, how and to what extent knowledge, structures, models, skills and values for working with parents with mental health problems and their children are addressed in policy and in professional education.

The aims and objectives of these reviews were established through a process of consultation with SCIE and the main body of work was undertaken between December 2006 and September 2007 with revisions added in response to reviewers' comments early in 2008. The reviews aim to be transparent and accessible[166] in both description of process and presentation of findings, and fit for purpose[166] in progressing the larger SCIE/NICE review of parental mental health and child welfare.

1.2 Context of the Reviews

Mental health has been the focus of much recent policy development[29,43] accompanied by increasing awareness of the impact of mental illness, not only on those who experience it, but also on family members, including children, and wider communities[41,66].

However, health and social care policy and services for adults and for children inhabit very different policy spheres and service structures are increasingly separate. The introduction of mental health trusts, primary care trusts (PCTs) and children's trusts has acted to intensify this separation. Such separation is increasingly acknowledged, but in the past much policy and guidance has relied on exhortations to collaborate rather than offering constructive mechanisms for doing so.

Additionally, variations and gaps in knowledge, attitudes and values between professional groups have been identified as barriers to delivering sensitive and co-ordinated services across the fields of parental mental health and child welfare[152,155,181]. Professional education at both qualifying and post-qualifying levels is one means of overcoming such barriers and of spreading relevant

knowledge across service divides. There is increased awareness amongst educators of the need for education and training which transcends the barriers between children's and adults' services and the review seeks to identify what opportunities are available in guidance on professional education for developing learning which addresses professional practice with parents with mental health problems and their children.

1.3 Review Methodology

1.3.1 Parameters of the Reviews

These were established in line with SCIE's commissioning brief. Mental health and mental health needs are contested concepts[167] but, for the purposes of this review, mental health needs were understood to embrace the full range of clinical diagnoses including minor disorders and personality disorders. Substance misuse was excluded from the definition of mental health needs although both reviews address the issue of substance misuse problems which occur in tandem with parental mental health need.

The review of policy covers documents for England published between 1989 (the date of the Children Act) and June 2007 (when searching for the review was completed). Acts of Parliament, Codes of Practice, White and Green Papers, Statutory Guidance, guidelines, practice guidance, consultations and a range of other policy documents such as National Service Frameworks were included.   With a few exceptions such as those identified below, the review was confined to publications produced by central government offices in England. Inquiries and serious case reviews into homicides and child deaths were excluded from the review as being too numerous to encompass. Analyses of relevant inquiry reports are available elsewhere[180]. However, some key inquiries and overviews of inquiries were used to provide context for these reviews.

While Acts of Parliament, Codes of Practice and Statutory Guidance are intended to be less discretionary in their implementation than other forms of policy, the relative weight of published policy is only one factor in determining its implementation. Numerous other factors, including the extent to which policy and guidance are monitored and resourced and are congruent with existing procedures and trends will also play a part in determining whether policy emerges into practice. However, legislation and statutory guidance are highlighted throughout this document and Table 1 offers a guide to the relative weighting and roles of the central government policy documents included in the policy review.

Table 1 Central Government Guidance Included in the Review of Policy – its force and weighting

Policy/Guidance	Force and weight
Acts of Parliament or Statutes Eg. Children Act 1989, Carers (Recognition and Services) Act 1995, Mental Health Act 2007	These set out the law which must be followed
Codes of Practice Eg Code of Practice Mental Health Act 1983	Public bodies and professionals implementing the law are required to have regard to Codes of Practice.
Statutory/Policy Guidance Eg. Framework for the assessment of children in need and their families 2000	Public bodies are expected to follow this unless they can show that they have good reasons for not doing so.
Practice Guidance Eg. Fair Access to Care Services Practice Guidance 2003	Advises public bodies on their statutory duties but does not need to be strictly followed

National Service Frameworks Eg. NSF for Mental Health Services 1999, NSF for Children and Maternity Services 2004	NSFs establish standards of care for key patient groups and provide strategies and targets to help organisations achieve this. These standards can be used for audit and inspection purposes.
White and Green Papers Eg. Care Matters: Transforming the lives of children and young people in care (Green Paper) 2006 Our Health, Our Care, Our Say: a new direction for community services (White Paper) 2006	These policy documents lay out the government's detailed plans and intentions for legislation. Green Papers are consultative, White Papers follow Green Papers and are therefore closer to the final form of legislation. However, changes made in the progress of legislation through Parliament means that the final form of legislation may differ from that envisaged in the relevant White Paper.
Best Practice Guidance Eg. Supporting women into the	This offers public bodies a recommended approach to commissioning or delivering services.

mainstream: Commissioning women-only community day services 2006	Implementation is not required.

NB. Adapted from SCIE's Adults' Services Knowledge Review 11[163]
These reviews do not aspire to the status of systematic reviews: the documents included are too diverse and numerous and the time-scale for the project did not allow for such an approach. However, the reviews are informed by the twin principles of specificity – in that they aim to maintain a clear focus on the linked issues of parental mental health needs and child welfare – and inclusivity. An inclusive approach was adopted to identifying policy and guidance documents in three service fields – children, mental health and adults (including some criminal justice publications). This ensured that some reports produced by bodies such as CSIP[43,67] and the Audit Commission[2] as well as influential reports produced by Royal College of Psychiatrists[32,36,40,56] and the recent Corston report[68] were included in the review of policy.

In some cases, a piece of policy or guidance is superseded by a later publication. Where this is clearly the case, as with the various editions of *Working Together*, the guidance on interagency work in child protection and safeguarding, the most recent edition was included in the review and earlier issues were excluded. However, in other cases, it was decided to include both earlier and later versions of policy documents to chart the development of policy over time. This had the effect of ensuring that both Green and White Papers were included in the policy review.

The review of professional education included the most recent guidance on qualifying and post-qualifying education for the following professional groups: Adult and child psychiatrists; clinical psychologists; social workers (adult mental health, child and adolescent mental health services and children and family services); community psychiatric nurses (adult mental health and child and adolescent mental health); occupational therapists, general practitioners, health visitors and midwives. Relevant publications on occupational and professional standards and requirements as well as those addressing workforce skills and development and the quality assurance of professional education were identified and included in the professional education review. This review also included additional material on professional training and education identified by the policy review. It was not possible to address the training and education offered by Local Safeguarding Children's Boards or that delivered locally by children's and mental health services as this would require a major study encompassing local policy and practice.

A small number of key stakeholders in the relevant professional education fields were consulted to provide advice and direction concerning which documents should be accessed and searched. Service users' and carers' perspectives on professional education's role in addressing parental mental health and child welfare were elicited through consultation with an 'expert' group; the findings are reported in Chapter 3 of this report. The remit of the review did not allow for user/carer literature on professional education to be

thoroughly searched but some supporting references from this field have been used to provide context for the interviews and the review.

1.3.2 Document Searching

Since policy and education in health and social care are rife with discussion of interagency and interprofessional communication, collaboration and work, and adults' and children's needs are frequently considered in tandem in the field of child care, we aimed to restrict the review as far as possible to specific references to parental mental health problems and children's needs. A list of search terms was drawn up by the research team and is shown in Appendix 2. Once identified, documents were searched electronically, using the key terms and also by hand. Occasionally, particularly when Acts of Parliament (which tend to be inclusive rather than specific in their language) were being searched, the relevance of particular guidance for parental mental health and child welfare had to be inferred. Hand searching, although time-consuming, allowed for this approach. Key passages were extracted and listed on a database and were then coded and sorted using analytic frameworks which were designed to reflect the key themes which emerged from the material. These are shown in Appendix 3.

Legal and policy documents included in the policy review were accessed through electronic and hand searches of government websites and through expert contacts. Initially, references of documents searched were screened to identify other relevant publications, but once familiarity with the field was established, the need to do this consistently was reduced.   The websites searched for the policy review are shown in Appendix 4.

Existing reviews of professional education undertaken by SCIE were also consulted for their relevance to professional social work education in parental mental health and child welfare. Relevant documentation for the education of other professions was predominantly accessed through online searches of websites of relevant professional organisations and government websites. Some professional organisations were found to include 'members only' areas on their websites to which access had to be negotiated and some proved easier to navigate than others.

All documents listed in References and in Appendix 1 were searched – not all of them provided relevant information and some reproduced text already found in other documents. Those documents which were searched but not used in the reviews are identified in Appendix 1. The Additional References list includes publications such as books or articles which were used to provide supporting evidence or context for the reviews; these were not subject to the methodical approaches used to search those documents which were the object of the reviews.

1.3.3 User and Carer Involvement

The limited time and resources available for undertaking this review had the effect of confining most of the consultation undertaken to one stakeholder group. It was agreed to concentrate on eliciting the views of users and carers to inform the review of professional education as this group constitutes the end-users of professional education. Interviews were organised through Comensus (Community Engagement and Service User Support) in the Faculty of Health at the University of Central Lancashire. Comensus is a community engagement initiative whose focus is the authentic involvement of people who have significant experience of using health and social care services, or caring for those who do, in all aspects of the university's business. The main focus of the project is the Community Involvement Team (CIT). The CIT comprises 20 diverse service users and carers, who are themselves linked into wider communities and activist groups. Members teach on a range of health and social care professional courses; they contribute to departmental and faculty management meetings and they are involved in research and in strategic planning and decision-making throughout the Faculty[146]. This level of involvement, combined with their personal experience, means that most CIT members have well developed knowledge about issues in health and social care professional education and hold views about the knowledge, skills and attitudes which they would like to see developed within and through professional programmes.

This element of the reviews required ethical approval which was granted by the University of Central Lancashire's Ethics Committee. Semi-structured individual interviews were carried out by the project researcher. Interviews were recorded and transcribed with the interviewees' permission. Their names have been anonymised in this report. Their contribution to this review allows us to consider the extent to which guidance on professional education reflects the aspirations and needs of service users and carers.

Chapter 2: Parental Mental Health and Child Welfare: Review of Policy

2.1 Context for the Review

Much of the policy development in both mental health and child care services in England and Wales over the last twenty years has been driven by inquiries into homicides and child deaths. The impact of individual high profile cases [157,160,170] filtered through the media[141], has resulted in a policy emphasis on risk and accountability[180]. Overviews of mental health inquiries and reviews of child deaths[151,169] have highlighted parental mental health needs as a factor in a proportion of cases although such reviews have varied in their definition of mental health problems and in the proportion of cases identified where perpetrators had a mental history. Stanley's (2004) study of women featured in mental health inquiries found that a number of the inquiries reviewed highlighted a failure by mental health professionals to identify women they were treating as mothers and to acknowledge the implications of that role for their mental health and their children's safety[179]. Concerns about mental health risks to women in the perinatal period were triggered by the Confidential Enquiry into Maternal Deaths in the United Kingdom[159,165] which found that suicide was the most common cause of death in the perinatal period.

Research has also played a role in raising awareness of the links between parental mental health and child welfare among policy makers and educators. Michael Rutter's work on the effects of parental mental illness on child development and his account of resilience[168,172] has been particularly influential. Subsequently, the review of factors impacting on parenting capacity undertaken by Cleaver et al in 1999[145] brought together the body of evidence in this field and ensured its accessibility to policy makers and practitioners in children's services. Research into maternal mental health in the perinatal period and its effects on children[147,164] has also had a significant impact on policy development and is extensively quoted in policy documents. An additional area of research activity has focused on interprofessional communication and collaboration and a number of studies have addressed the interface between adults' and children's services and identified gaps[161,181].

2.2 Structure of the Review

Three key themes emerged from analysis of the material collected for this review:

1. Comprehending the relationship between parental mental health and child welfare

2. Moving Towards a Family Focus: recognising multiple needs and communicating and working across service divides

3. Planning and Delivering Services

Sub-themes were identified within these themes and provided a structure for sorting and collating the findings presented here. They are outlined in full in Appendix 3 and the section headings in this review follow these sub-themes although in areas where material was limited, sub-themes have been merged.

2.3 Comprehending the Relationship Between Parental Mental Health and Child Welfare

2.3.1 Prevalence and Associations

Much of the policy and guidance searched is concerned with articulating the nature of the relationship between parental mental health needs and child welfare and is aimed at developing an understanding of the nature of the associations between the two issues. The adverse effects of parental mental health problems on children emerge as an overriding theme across the three main policy fields searched – children, mental health and adults.

The review identified some attempts to quantify the extent of parental mental health problems and their negative impact on children. Such broad estimates are usually, but not always, linked to research evidence as shown in these extracts:

> Around 450,000 parents have mental health problems. Poor parental mental health is significantly associated with children's own mental health and their social and emotional development. For example, the children of parents with mental ill-health are twice as likely to experience a childhood psychiatric disorder (p20[70]).

> ……Post-natal depression is estimated to affect one in ten new mothers and usually starts within six weeks of the birth. Research suggests that a mother's prolonged post-natal depression may have a negative effect on the child's cognitive development and social relationships (p75[41]).

> Research suggests that parental mental ill health can have a major impact on children. Some estimates suggest a third to two thirds of children will be adversely affected (p17[35]).

The 'broad stroke' approach of policy and guidance documents rarely allows for the elucidation of the difficulties inherent in defining mental health problems or mental illness. It is consequently often unclear for the reader of such documents whether the terms 'parental mental health problems' or 'mental disorder/ill health' refer to parents with a diagnosable disorder who use specialist mental health services; to those who, like most mental health service users, are treated in primary care or whether such estimates include parents with mental health problems in the general population who are undiagnosed and untreated. A similar lack of specificity was found in relation to the developmental and psychological effects for children which are described in varying terms across the documents searched.

While estimates of prevalence serve to emphasise the widespread nature of the issue and its relevance for practitioners, some policy and guidance documents also note the complexity of the relationship between parental mental health and child welfare. For instance, the Social Exclusion Task Force report *Reaching Out: Think Families. Analysis and Themes from the Families at Risk Review* points out that major mental illnesses can be transmitted to children both genetically and environmentally (1.40, p20[70]) and the Green Paper, *Every Child Matters* notes that 'research has not built up a detailed picture of the causal links' (1.10, p17[8]). However, such caution concerning the direction and strength of causal relationships between parental mental health and child welfare was rare in the policy documents searched. The more common approach found in the *Framework for the Assessment of Children in Need and their Families*[4], and in a number of the documents searched, stresses that adverse effects are not inevitable for children:

> Such problems may adversely affect a parent's ability to respond to the needs of his or her child. While some children grow up apparently unscathed, others exhibit emotional and behavioural disorders as a result of these childhood experiences (p25[4]).

Policy documents published after 2001 were more likely than those published earlier to identify parental mental health problems as sequelae of experience of childhood abuse[6,33,36,37,42]. *The Review of Women with Particular Vulnerabilities in the Criminal Justice* System[68] emphasises that many women in prison who have a high level of mental health needs have a history of serious sexual or other forms of violent abuse. Reports and guidance from the same period also appear more ready to highlight the ways in which the demands and stresses of parenthood can contribute to parental mental health problems:

> The stresses of parenthood can precipitate or exacerbate mental ill health. Furthermore, children, especially those with chronic physical/developmental or emotional disorders, can precipitate or exacerbate parental mental illness (p8[36]).

Separation from and concern over their children are identified as key factors contributing to the poor mental health of women in custody[67,68].

While noting that: 'Mental illness in a parent or carer does not necessarily have an adverse impact on a child's developmental needs', children's services documents stress that: 'it is essential always to assess its implication for each child in the family' (9.16, p186[18]). The Framework for the Assessment for Children in Need and their Families[4] conceptualises parental mental health problems as one factor in the construct 'parental capacity' and emphasises its role as one among a range of family and environmental factors with which it interacts.

Throughout the policy and guidance searched, the language used in relation to parents with mental health needs is frequently ungendered and *parental mental health* was the term most commonly found. However, when parental gender is identified in relation to parental mental health needs it is virtually always

mothers who are discussed: the needs of women are highlighted in guidance on perinatal mental health and maternity care, in the reports on women prisoners included in this review and by the Women's Mental Health strategy documents.[35,37,42] Only one reference was found to fathers' mental health in practice guidance on Sure Start Children's Centres; this was in relation to engaging fathers in antenatal and postnatal care and argued the need for 'dad focused materials' as well as emphasising the potential for fathers to develop post-natal depression[19].

2.3.2 Adverse Effects of Parental Mental Health Problems on Children's Development

Considerations of adverse effects on children's development in the guidance highlight in particular the mental health of *mothers*. This emphasis appears to derive from both research studies in the field of perinatal mental health and from the focus of certain professional groups such as health visitors and perinatal psychiatrists on the health of mothers:

> Prolonged postnatal depression is associated with adverse effects on the mother–infant relationship and the emotional state of the infant. There are well-described long-term effects on the later social attachments and cognitive development of the child, particularly of boys, that are detectable after the resolution of the maternal illness (Kumar & Hipwell, 1994; Cooper& Murray, 1995) (p10[32]).

> *Improving infant, child and family mental health*
> The rate of psycho-social disorders amongst children is 10-15% in the UK with levels being particularly high in areas of deprivation (Department of Health, 2007) and maternal mental health has a significant impact on child development and the wellbeing of families (p20[57]).

The differential impact of postnatal depression on boys cited in the Royal College of Psychiatrists report on perinatal mental health services and quoted above is picked up and reiterated in the context of highlighting the saliency of early years experience by the Green Paper, Every Child Matters (1.14[8]).

In a number of policy documents, the negative effects of postnatal depression on child development inform an argument for early intervention:

> Maternal post-natal depression, with a prevalence of 10 – 15%, has been shown in several studies to have adverse effects on the baby, including insecure attachment, cognitive development deficits and increased likelihood of psychiatric illness, and some of these can persist in the longer term. The identification and management of psychological health therefore is crucial for the child as well as the mother (p34[51]).

The Cabinet Office *Reaching Out* Action Plan adds anti-social behaviour in children and adolescent offending to the list of consequences of postnatal depression (4.30, p46[66]).

Policy and guidance from all fields covered by this review draw attention to the association between parental mental health problems and mental health problems in children and young people. The Royal College of Psychiatrists report, *Child Abuse and Neglect,* highlights the risk of 'conduct disorder in boys' (p20[40]). However, publications in the policy fields of children's and adults' services tend to refer more broadly to 'emotional and behavioural disorders' (2.21, p25[4]) or childhood psychiatric disorder' (1.39, p20[70]).

2.3.3 Abuse, Neglect and Looked After Status

The risks of abuse or neglect for children whose parents have mental health problems are raised across all policy fields searched. The Royal College of Psychiatrists report, *Patients as Parents*, highlights the risks of emotional abuse and notes that its effects can persist into adulthood (p15[36]). This report also notes that hostile behaviour towards children is most characteristic of parents with a dissocial personality disorder' (p16-17[36]). Working Together[18] stresses that those children most at risk of significant harm are those who feature in parental delusions or who are the target of parental aggression or rejection. A number of the documents reviewed[35,40,48] note that risks for children are increased when mental health problems co-exist with other issues such as substance misuse, domestic violence or learning disabilities. A rare (in the context of this review) readiness to question the links between risks for children and parental mental health problems is advocated by the 2006 *Review of the Care Programme Approach:*

> Where there are concerns about a child (including unborns) they need to be specific to the child i.e. would they be there whether the parent had a mental health problem or not? If the concerns are related to parental mental health then recording should be specific about what the concerns are being attributed to eg. severity, duration, history, dual diagnosis, compliance with treatment (p30[43]).

The review found a limited number of references to the association between parental mental health needs and children entering the looked after system. However, there is substantial research evidence for parental mental health problems as a key factor in children's admission to the care system and some of these studies are cited in the relevant documents[11,36,41]. The White Paper, *Care Matters: time for change* notes that 'increasing numbers of children are entering care because of the particular needs of their parents' (p36[21]). The Review of Women with Particular Vulnerabilities in the Criminal Justice System[68] identifies the substantial proportion of women prisoners' children who enter the looked after system as a consequence of their mothers' imprisonment.

2.3.4 High Risk

Inquiries into child deaths have focused the attention of the public and policy-makers on the high levels of risk which parental mental health problems can occasionally represent for children. A number of the documents reviewed identify the risk of child death and cite inquiry reports and overviews of such

reports[151] as evidence[18,32,40,67]. Psychotic disorders, depression and personality disorders are singled out as being the parental diagnoses most commonly associated with nonaccidental deaths of children[40].

The risks associated with fabricated or induced illness are flagged up in the DH et al guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced*[6]. However, an uncertainty surrounding the association between this label and parental mental health problems is evident in the statement that some parents 'may have been diagnosed with a personality disorder, but others may have no diagnosable psychiatric disorder' (p17[6]). Likewise, the Royal College of Psychiatrists report*, Child Abuse and Neglect*, notes that the outcomes for children affected by fabricated or induced illness have not been subjected to rigorous research (p21[40]).

2.3.5 Association with Social Exclusion

The social exclusion agenda has been a strong theme in the UK government's social policy for the last ten years. However, its first explicit link with parental mental health problems in government policy is found in the Social Exclusion Unit's report Mental Health and Social Exclusion[41] where it is emphasised that parental mental health problems are one of a number of aspects of social exclusion which contribute to poor outcomes for children:

> Parental mental health problems can, but do not always, have a significant impact on children's social and emotional well-being by disrupting the attachment bond between infants and parents. A number of factors will determine how, and to what extent, parental mental health problems impact on a child's health and well-being. The severity of the diagnosis alone may not be a good guide because access to treatment, support, social and economic circumstances can have a significant impact on whether the child develops their own mental health problems (p75[41]).

In this document, parental mental health problems are both seen to contribute to social exclusion – the report notes that parents with mental health needs are less likely to be in employment than other parents – but are also seen to occur in tandem with a range of other characteristics of social exclusion. Here, as in other documents the direction of the relationship between parental mental health needs and social exclusion is unclear.

Earlier reports from the Royal College of Psychiatrists[36], the DfES[4], and those on women's mental health services[35,37] had already emphasised the significance of a multiplicity of social problems and the issue of limited access to services in mediating the impact of parental mental health needs on children. However, the influence of the social exclusion agenda is immediately apparent in the *National Service Framework for Children*[48] and in the 2006 version of *Working Together to Safeguard Children*[18]:

Many of the families who seek help for their children, or about whom others raise concerns about a child's welfare, are multiply disadvantaged. These families may face chronic poverty, social isolation, racism, and the problems associated with living in disadvantaged areas, such as high crime rates, poor housing, childcare, transport and education services, and limited employment opportunities. Many lack a wage earner. Poverty may mean that children live in crowded or unsuitable accommodation, have poor diets, health problems or disability, are vulnerable to accidents, and lack ready access to good educational and leisure opportunities. Racism and racial harassment are an additional source of stress for some families and children. Social exclusion can also have an indirect effect on children, through its association with parental depression, learning disability, and long-term physical health problems (p185-186[18]).

One of the distinguishing features of more recent reports from the Social Exclusion Unit is the emphasis on recognising the costs of social exclusion:

The failure to address social exclusion can levy high costs on children, parents, families, the community and wider society, in terms of poor life experiences and future prospects.

Families facing multiple problems do not just have an impact upon themselves. They also impose a high cost to society, be it through the costs of support services or in some cases through lost productivity and the costs of policing anti-social behaviour.

In Aiming high for children: supporting families[26] HM Treasury calculated that families experiencing five disadvantages (depression, alcohol misuse, domestic violence, periods of homelessness and involvement in criminality) can cost the state between £55,000 and £115,000 a year. These figures reflect the cost of parental problems only. Children with additional support needs can add to the cost of the family. It is estimated that the cost per case for a child with additional support needs and who is in care is almost £300,000 (p24[70]).

Key aspects of social exclusion linked with parental mental health problems by SEU reports and by earlier reports include lone parenting[35,41] which is associated with low income and benefit dependence and young parenthood (conceptualised in the reports searched as commensurate with young *mothers*) which is associated with socio-economic disadvantage, low birthweight and infant mortality as well as with low uptake of perinatal services[35,48]. The co-existence of domestic violence with maternal mental health problems is identified by a range of reports where its role in contributing both to women's mental health needs and to risks to children's safety is acknowledged.[36,37,40,48] The role of parental learning disabilities, either on their own or in combination with parental mental health problems, in restricting parents' capacities to meet children's needs is flagged up by the Royal College of Psychiatrists report, Patients as Parents[36]. The frequency of the co-existence of substance misuse

with mental health problems is also emphasised[37] and the increased risks to pregnancies and to children when the two occur together are stressed[36,48].

Limited access to services is one aspect of social exclusion which is noted to occur in tandem with parental mental health problems and with substance misuse. The report, *Positive Steps: Supporting Race Equality in Mental Healthcare*[45] emphasises that restricted access to services may be a particular issue for minority ethnic groups who may lack knowledge of services, may encounter attitudes which suggest that the community 'should look after their own' and experience language barriers. This and other reports[41] emphasise the relationship between experience of domestic violence and depression in Asian communities and note the high rates of enduring mental health problems among Black Caribbean single mothers. Working Together to Safeguard Children[18] notes that racism and racial harassment can represent additional sources of stress for minority ethnic families.

A high level of mental health problems is also identified as characteristic of mothers in the prison system[67,68,69]. These include both serious mental illness and low level mental health problems. The widespread occurrence of self-harm in this group is also highlighted.[68,69] The Review of Women with Particular Vulnerabilities in the Criminal Justice System[68] follows the report, *Women's Mental Health: Into the Mainstream*[35] in arguing that women have limited access to appropriate community mental health services. The report also describes women's access to mental health services in prison as poor with delays in transferring women to special hospitals, delays in the use of formal orders under the *Mental Health Act* and a lack of involvement from specialist mental health staff in care and treatment while women are in prison (p73[68]). The rural location of some women's prisons is identified as causing particular problems in terms of both the unpreparedness of some local health services to respond to women's mental health needs and the problems experienced in relation to maintaining contact with children.

The stigma associated with mental health problems is acknowledged to impact on both parents with mental health problems and their children by a number of more recent policy documents surveyed. The various effects of such stigma identified include bullying of children in school[41], an unwillingness on the part of parents with mental health problems to disclose information[47] and a propensity on the part of professionals to question and so undermine parenting abilities[41]. The Implementation Guidance for *Mainstreaming Gender and Women's Mental Health*[37] acknowledges that the experience of such attitudes can dissuade parents with mental health problems from accessing services and states that:

> All relevant services need to acknowledge that having a serious mental illness does not necessarily mean that women cannot be 'good' parents (p51[37]).

The theme of stigma recurs in the Review of Women with Particular Vulnerabilities in the Criminal Justice System[68] which identifies the additional stigma conferred by prisoner status:

"To become a prisoner is almost by definition to become a bad mother. If she has a husband or partner then again almost by definition she will become a bad wife or partner" (p20 Baroness Hale[68]).

2.3.6 Resilience

We noted earlier that an emphasis on the risks associated with parental mental health problems is offset in policy and guidance by references to the complexity of the association between parental mental health problems and adverse outcomes. Resilience is identified as a key factor in mediating this relationship. Resilience is alluded to in a number of the policy documents searched. It is sometimes referred to as 'protective factors' and is broadly interpreted as encompassing both environmental and child specific factors:

Children who adapt well to a parent's mental illness will typically exhibit at least some of the following:

• older age at the time of the onset of their parent's illness (because of reduced opportunities for exposure to difficulties and development of a greater range of potential coping resources)
• being more sociable and able to form positive relationships (having an easier temperament)
• greater intelligence
• a parent who has discrete episodes of mental illness with a good return of skills and abilities between episodes
• alternative support from adults with whom the child has a positive, trusting relationship (p17[36]).

However, the aspect of resilience most frequently identified in the documents searched is the presence of another family member with whom the child has a protective trusting relationship[4,18,36,40].

2.4 Moving Towards a Family Focus: Recognising Multiple Needs and Communicating and Working Across Service Divides

This section of the review addresses the ways in which policy and guidance actualise understanding of the links between parental mental health and child welfare. Responsibilities and duties to take account of children's needs are identified and there is a widespread emphasis on prioritising children's needs over those of adults. The review also found a substantial body of injunctions for practitioners, managers and planners to maintain an awareness of the needs of the service user group other than their own and young carers are a group whose existence and needs are consistently flagged up. A number of tools and operational mechanisms emerge from this part of the review which are aimed at fostering this attitude of looking beyond service divides and towards developing a focus on families. This section of the review also includes guidance and policy on interagency co-ordination, collaboration and communication and the related issue of confidentiality in information exchange.

2.4.1 Duties to Prioritise Children's Needs

Section 11 of the *Children Act* 2004 requires all local authorities, health trusts, health authorities and criminal justice organisations to have 'regard to the need to safeguard and promote the welfare of children' in discharging their functions (s11, 2a[9]). This duty is flagged up for adult services in the White Paper, *Our Health, Our Care, Our Say: A New Direction for Community Services*[55]. Working Together to Safeguard Children[18] emphasises the statutory duties of health and adult social care and criminal justice services to have arrangements in place for effective interagency communication aimed at promoting children's safety and welfare. The implications of this duty for staff in mental health services are spelled out:

> Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area (2.92, p59[18]).

While Section 27 of the Children Act 1989 had already established a qualified duty on education, health and housing services to cooperate with local authorities in relation to supporting children in need and their families[1], the updated version of the statutory guidance on Section 11[25] identifies the duties relevant for local authorities, the police, the probation service, NHS bodies, Connexions, youth offending teams, prisons and young offender institutions, secure training centres and British Transport Police. The Statutory Guidance reflects the influence of the Laming Inquiry[157] in requiring these organisations to demonstrate senior management commitment to safeguarding and promoting children's welfare; to provide all staff with a clear statement of the agency's responsibilities towards children and to establish a clear line of accountability for work on safeguarding children and promoting children's welfare (p13-14[25]).

 Policy and guidance issued across the time-span of this review are consistent in emphasising that staff working in adult or health services have a responsibility to report children at risk of harm and to contribute to the support of children in need. Guidance for mental health practitioners refers explicitly to disclosures of child abuse which may be made by adults[27]. The guidance on Safeguarding Children in Whom Illness is Fabricated or Induced identifies the potential for staff to experience 'conflicts of loyalty' (p37[6]) in such situations and the Royal College of Psychiatrists notes that the duty to protect children overrides the duty of patient confidentiality (p15[36]). The National Service Framework for Children[48] underlines this duty to prioritise children's needs:

Adult Health Services (Mental Health, Substance Misuse and Others)
Where parents or carers have problems that result in them not being able to respond to their children's developmental needs, the safeguarding of children (including the unborn child) is a priority in any assessment or ongoing treatment of the parents (p156[48]).

Children's services staff are also warned of the dangers of allowing parental mental health needs to distract them from prioritising children's needs:

> In complex situations where much is happening, attention can be diverted from the child to other issues which the family may be facing, such as a high level of conflict between adult family members, or depression being experienced by a parent or acute housing problems. This can result in the child becoming lost during assessment and the impact of the family and environmental circumstances on the child not being clearly identified and understood. The significance of seeing and observing the child throughout any assessment cannot be overstated (p10[4]).

2.4.2 Looking Across the Gaps

Some way below the statutory duty for all agencies to promote and safeguard children's welfare comes the guidance which seeks to ensure that staff working in one service are alert to the needs and welfare of those who are the primary users of another service. Much of this guidance identifies a need for staff in adult and mental health services to recognise that many of their service users are parents and to acknowledge that children in the family may have unmet needs:

> Greater awareness in adult mental health services of children's needs will help services work more supportively with parents who have mental health problems and can improve children's emotional and mental well-being (p72[41]).

> Professionals working in adult services appreciate the importance of identifying the patient's or client's role as a parent or carer. They are able to consider the impact of a parent's condition or behaviour on the child's development, the family functioning and their parenting capacity, with a view to signposting or referring to services to provide them with additional support (p80[48]).

The implementation guide on *Support, Time and Recovery (STR) Workers in mental health services* emphasises their role in working with all family members and provides an example of an STR worker offering support and accessing services for both a mother with mental health needs and her young carers[38].

The division of local authority social services into children's and adults' social care has been accompanied by acknowledgement that adults and children live

together in families and that the separate services responding to their needs require co-ordination at senior management levels:

> The introduction of the post of DASS alongside the Director of Children's Services will ensure that all the social care needs of local communities are given equal emphasis and are managed in a coordinated way. The relationship between these two posts will be crucial to ensuring that the needs of both adults and children in families are met and that services work well together (p44,[65]).

Some mentions of the need for practitioners in children's services to acknowledge the role of mental health needs in determining parenting capacity were found[36,43,66]. The Royal College of Psychiatrists[36] notes that mental health problems in parents may go undetected and untreated if the links between child welfare and parental mental health needs go unacknowledged. The Women's Mental Health Strategy also touches on treatment, and suggests that the consequences of mental health interventions should be considered for children in families where mothers have mental health needs (p41[35]).

2.4.3 Young Carers

Section 1.1 of the *Carers (Recognition and Services) Act* 1995[59] gives young carers a right to a carer's assessment and the guidance on the Act[60] notes that those undertaking such assessments should also have regard to the relevant sections of the Children Act 1989 which gives them responsibilities for supporting families where children are in need and a duty to assist other local authority departments in responding to those needs. The guidance[61] also emphasises the impact of caring on a child's development and welfare and recognises the implications of young caring for the parent-child relationship:

> Where the carer is a child the impact of caring may be different as it may affect the child's health and development by the restrictions that providing regular and substantial care might place on the child's educational and leisure opportunities. This should be carefully considered as part of the assessment. It is equally important that the assessment focuses on how best to enable an ill or disabled parent (or other family member) to live independently so that the parent's ability to parent is supported rather than undermined (p7[60]).

The guidance notes that community care services for the service user being assessed or for the young carer should be considered even if the young carer does not request a carer's assessment[60]. Guidance on direct payments issued in 2003 directs the local authority to consider approving direct payments in the small number of cases where a 16 or 17 year old is undertaking a substantial caring role and the local authority supports that decision. Such payments might be used to minimise the impact on the young carer's education or to offer them a break from caring[63].

The position and needs of young carers are brought to the attention of mental health services by the two Building Bridges reports[27,30]. *Still Building Bridges* emphasises that 'where users agree, carers including young carers, are encouraged to participate fully in assessment and care planning' (p63[30]). Child care social workers are alerted to the potential for children of parents with mental health problems to be accorded the status of young carers and their rights to a carer's assessment by the Framework for the Assessment of Children in Need and their Families[4]. The status of young carers is reinforced by the Mental Health Act 2007 which, while not explicitly mentioning them, establishes the need to address the 'views of carers and other interested parties' (s8) as part of the general principles informing the Act[46].

The needs of young carers and the extent of young caring are also flagged up in reports from the Royal College of Psychiatrists[36], the National Service Framework for Children[48] and the Social Exclusion Unit[41,70]. Such documents tend to emphasise the adverse effects of young caring for children and young people, although the SEU report also highlights the value of services targeted at young carers (p77[41]). It is notable that the concept of young carers is used mainly in adult services policy. The concept is not subject to detailed critical scrutiny by policy and guidance although the Framework for the Assessment of Children in Need notes that a young carer may also be a child in need under the Children Act 1989[4]. The National Service Framework for Children refers obliquely to the way in which young carers may be replacing inadequate services when it argues:

> …Families who rely on their children as unpaid carers need support to relieve the children of their caring responsibilities which can have an adverse impact on their development and life chances (p79,[48]).

2.4.4 Care Programme Approach (CPA)

The Care Programme Approach (CPA) is identified in policy and guidance as a key mechanism for bridging the gap between parents' and children's needs and services[36,37,43,48]. It provides a system for assessing, planning and reviewing the care of mental health service users in which key workers or care coordinators play a lead role and the *National Service Framework for Mental Health* emphasises that these processes involve 'multi-agency endeavour (p45[29]). Mental health service users are currently assigned to one of two levels within the CPA: standard or enhanced; the consultation report reviewing the CPA proposes replacing these two levels with one single level for service users whose needs are 'complex' and where the required service response will also be 'complex'[43]. The National Service Framework for Mental Health[29] ushered in the integration of the CPA with social services care management systems. However, the need for the CPA to adopt a more holistic approach which takes account of social as well as clinical needs has continued to be highlighted. The implementation guidance for Mainstreaming Gender and Women's Mental Health suggests that:

Importantly, the CPA needs to be placed within the broader context of women's lives e.g. take account of their family, social and economic realities and inherent conflicts and obligations alongside their strengths, aspirations and competencies (p24[37]).

The policy booklet, *Effective Care Co-Ordination in Mental Health Services: Modernising the CPA*, argued that children's services staff should be involved in hospital discharge planning when child care issues are identified[28]. The Working Together to Safeguard Children guidance[18] advocates that mental health practitioners should routinely record patients' responsibilities in relation to children and the Review of the CPA also argues that the CPA should address the needs of adults who are or are about to be parents and those of their children:

> Including the needs of adults as parents into the CPA will re-enforce the understanding that adults with mental illness may also be parents and that this needs to be taken account of in assessment and care planning. This means identifying whether the child is also in need, including need of protection due to the direct or indirect impact of the mental illness. The fact that an adult is also a parent (or about to be a parent) should be addressed at every stage of the assessment, care planning and review process as should the needs of the wider family (p30[43]).

Care programme planning meetings are identified as opportunities for identifying children's needs and possible risks for them in various pieces of guidance[36,48]. The *Mental Health Policy Implementation Guide for Community Mental Health Teams* suggests that the well-being of children who may be affected by parental mental illness should be routinely assessed as part of the CPA process[34]. The document notes that, while adult CMHT staff are not trained to assess parenting, they can recognise when a service user's problems constitute a risk or burden for a child (p13[34]). The Review of the Care Programme Approach consultation document[43] suggests that, if a child is on the Child Protection register, then the CPA documentation and review should explore and identify the inter-relation of the adult's and child's care plan. Since the Child Protection register is due to be phased out and replaced by ContactPoint (see Section 2.4.6 below), mental health practitioners will need to familiarise themselves with and access the new system. Consultation on the Mental Health Bill elicited suggestions from children's voluntary organisations that a duty to ensure that the needs of children were assessed as part of a parent's care plan should be incorporated into mental health legislation. However, the government's response was that mental health legislation was 'not the appropriate vehicle for achieving this'[39] and the Mental Health Act 2007 does not address this issue[46]. The *Draft Illustrative Code of Practice on the Mental Health Act* suggests that after-care plans should take into consideration both mental health patients' wishes and needs and 'those of any dependent' (p143[44]).

There are also suggestions for extending the use of the CPA in relation to women prisoners. The *Women at Risk* report[67] recommends that PCTs should support Inreach teams to offer mental health care to women in prisons using

the CPA to develop care plans which can be followed through when women are transferred or released.

2.4.5 Fair Access to Care Services (FACS)

Fair Access to Care Services (FACS) policy guidance[62] defines the eligibility bands introduced in 2003 to inform the allocation of local authority care services to adults. The Practice Guidance[64] draws attention to the needs of adults who are parents and may have parenting needs. The Practice Guidance notes that where adults have needs that impact on their parenting and may affect their children's well-being, it might be appropriate for the Framework for the Assessment of Children in Need and their Families to be employed, but emphasises that parenting roles and responsibilities come within the FACS eligibility criteria which address family and other social roles and responsibilities (p11[64]). The Practice Guidance incorporates a case example of a single mother whose parenting is compromised by her mental health difficulties and stresses that such a case should be given a rating similar to that of an older person who cannot perform vital personal care tasks (p11[64]).

FACS assessments and reviews are intended to be integrated into or aligned with the delivery of the CPA and health professionals can undertake FACS assessments on behalf of the local authority[62]. However, research has suggested that the implementation of FACS in community mental health settings has been slow[142].

The Green Paper, *Independence, Well-Being and Choice,* notes that eligibility criteria for adult social care services may need to shift if preventive interventions are to be introduced[65]. However, it argues that policies and protocols outlining how children's and adults' services can work together can make for cost-effective services and can ensure that children's needs are promoted by providing support to parents.

2.4.6 Interagency Communication

Interagency and interprofessional communication are identified as key mechanisms for closing the gaps between children's and adults' services. The Cabinet Office Reaching Out Action Plan highlights that information exchange is crucial:

> The challenge is to bring these strands of work into a coherent whole-family approach for families with the greatest needs. Of paramount importance are: identifying problems across family members and sharing information; analysing how services engage with and work with families with additional and complex needs (p68[66,70]).

The importance of mental health practitioners sharing information with children's services is emphasised in relation to cases where risks for children may be high[6,18,27]. The Royal College of Psychiatrists report, Child abuse and

neglect, suggests that mental health practitioners' concerns about children's safety should be communicated to social services in writing (p25[40]). This report also notes that confidentiality can be 'a potentially contentious issue' (p5[40]) which can impede information exchange and suggests that colleagues in child and adolescent psychiatry may have a role in facilitating communication between adult psychiatry and children's services.   The non-statutory guidance[20] on information sharing produced for practitioners under the Every Child Matters agenda confirms that, where there is a risk of significant harm to children, confidentiality can be breached without seeking parents' permission. Additional guidance stresses that professionals can share information across service boundaries even in the absence of local information sharing agreement[24].

The Green Paper, Every Child Matters[8] introduced a number of tools which aim to facilitate communication between agencies and professionals. These include the Common Assessment Framework (CAF), the Integrated Children's System (ICS) and ContactPoint (formerly known as the Information Sharing Index). The CAF provides a common local framework (in electronic format when fully implemented) for practitioners from different agencies working with children to contribute to initial assessments[14] The Integrated Children's System is an information technology system which has been developed and piloted and is, at the time of writing, in the process of being implemented in England by local authorities.   It aims to provide a electronic format which can be used by social workers for assessing and recording work with all children identified as 'in need'. It also has potential as a management and audit tool[22]. ContactPoint which, at the time of writing, is still under development, is described as an information technology system which will hold core demographic data on every child in England and will include contact details of practitioners providing services to a child. Due to the sensitivity of the information, contact details of mental health practitioners involved with a family will only be made available to other professionals where families have given their consent for this to happen[23]. These tools are currently either newly introduced or still under development and it is not as yet clear to what extent practitioners from adult services will have direct access to the information stored or whether they will contribute directly to such records. While communication between professionals providing services to children in health, social care education and youth justice services may well be facilitated by such tools, practitioners in mental health services appear less likely to make direct use of such systems.

2.4.7 Interagency Collaboration and Co-ordination

The policy and guidance reviewed here are strewn with exhortations for agencies and professionals to collaborate and co-ordinate their work. However, here we focus on the structures and mechanisms identified as a means of achieving this.   Within children's services, the Every Child Matters agenda has introduced a number of such structures aimed at effecting closer integration of health and social care services for children. Integrated Children's Trusts were announced in the Treasury Spending Review for 2002[7]. The Children Act 2004[9] sought to strengthen structures for collaboration at a strategic level between local services for children and families through the creation of Local

Safeguarding Children Boards. Children's centres have been established to offer a range of integrated services for children and families including family support, community health services, early education and childcare[55]. However, the Social Exclusion Task Force recognises that gaps between children's and adults' services persist and the Reaching Out report[70] considers ways of addressing these:

> …opportunities to extend the logic of the reforms in Every Child Matters to support the whole family. The application of key principles such as a common vision, clear accountability, multi-agency working, information sharing and core processes and assessments have helped to address the impact of parental risks on the child. We now can take this further by getting adults' and children's service to work together more effectively to better tackle adult-based risks within the family (p57[70]).

This continuing gap between adults' and children's services is also identified by the 2007 White Paper on looked after children[21].

The Reaching Out Review[66,70] highlights the role of the lead professional as a mechanism for increasing service integration and responsiveness. In children's services, the role of lead professional was introduced by the Every Child Matters Green Paper[8]. The lead professional co-ordinates services for children and their families and acts as a single point of contact for the family. They are being implemented in England from 2006 to 2008 and the concept of budget holding lead professionals is being piloted at the time of writing[16]. While the lead professional role can in theory be assumed by any one of a number of professional groups, it appears unlikely at present that mental health practitioners will aspire to that role.

Other mechanisms advocated as means of achieving improved co-ordination between services include establishing core standards of care which specify close working relationships between services[32]: this is proposed in relation to collaboration between children's and adults' mental health services[32] and between specialist and primary health services[36,37]. The need for close collaboration with local voluntary organisations is also identified[37,59]. The practice guidance for Sure Start Children's Centres[19] emphasises the need for Sure Start staff working with families with mental health problems to establish networks and partnerships for working with mental health services. The guidance suggests appointing 'mental health champions' (p57[19]) who would take responsibility for highlighting opportunities for joint working.

Multi-agency forums and panels, such as those established for multi-agency work with sex offenders and domestic violence, are suggested as potential structures for achieving closer co-ordination of services[37,70]. Managed care networks are also advocated: these are locally based linked groups of professionals with locally agreed membership, focus and remit[52]. They have the capacity to deliver care pathways which offer service users an established referral route across service boundaries and allow for standards and measures to be attached at various points along the route[56]. Care pathways are identified

as a means of facilitating collaboration between mental health services, maternity care and children's services in perinatal care[37].

However, the barriers to establishing such arrangements in the field of parental mental health and child welfare are described in the Royal College of Psychiatrists report, Child Abuse and Neglect:

> Child abuse and neglect may lead to a conflict of interest between child and parent, if the parent denies abuse that the child has described, or when the child cannot be cared for safely and adequately by one or both parents. This conflict may be mirrored in interactions between professionals who may see their primary responsibility as promoting the interests and needs of one particular member of a family. The child's and the family's needs can only be met adequately by interprofessional cooperation (p8[40]).

The Royal College of Psychiatrists reports[36,40] emphasise the importance of practitioners recognising the limits of their own expertise and the remits and expertise of other professionals. For example, the Child abuse and neglect report notes:

> The role of adult and addiction psychiatrists, in addition to providing support and treatment for their patient, is to liaise with child care professionals and to provide, if required, an assessment of the parent, the parent's mental health problems, previous functioning and prognosis, rather than to provide a specific assessment of parenting capacity (p20[40]).

2.5 Delivering Services

This section of the review moves away from the themes of developing understanding and looking across service barriers to consider the delivery of services for parents with mental health problems and their children. Here, the focus is on services which are identified in policy and guidance as specific to or relevant for this group. Both existing services and those proposed or under development are considered here.

2.5.1 Commissioning and Auditing

The White Paper, Our Health, Our Care, Our Say: A New Direction for Community Services[55], proposes that the Directors of health and social care organisations undertake joint strategic needs assessments and reviews of the needs of local populations. This document, like others before it [29,60], stresses the need for commissioning to be informed by the views of children, young people, their families and the wider community.   Likewise, the strategy for commissioning women-only community day services[42] argues that planning and purchasing of such services should be informed by local consultation with a wide range of stakeholders. This document provides guidance on how

potential users of such a service can best be engaged in planning and recommends the establishment of a multi-agency group to drive the commissioning process forward. It uses the new public sector Gender Equality Duty as a driver for introducing women-only mental health day services and identifies key principles and a service specification for such services while emphasising their potential diversity.

Maternity services are those where the link with mental health provision is most frequently identified as a relationship which can be built into commissioning. The NSF for Children introduces this 'marker of good practice':

> *Maternal Mental Health*
> Maternity services are commissioned within a context of managed care networks and include a range of provision for routine and specialist services for women and their families e.g.: Services for women and their partners who have mental health problems (p5[51]).

The need for early investment to promote the health of pregnant women is reiterated in the Department of Health's *Commissioning Framework for Health and Well-Being*[58] which evokes the statutory duty of co-operation imposed by the Children Act 2004 as a driver for joint commissioning. This document also advocates the commissioning of 'practice-based multi-disciplinary mental health resources'(p52[58]).

The Green Paper, Every Child Matters[8], calls on local authorities to work with the independent sector to develop home visiting programmes for parents in the perinatal period and services for the management of postnatal depression. The suggestion that mother and baby units for women with severe postnatal mental health disorders should be jointly commissioned by a number of health authorities is made by the Royal College of Psychiatrists[32] and is reiterated by the National Service Framework for Children[51].

The need to commission adequate mental health services for women in custody is addressed by both the Women at Risk Report[67] and The Review of Women with Particular Vulnerabilities in the Criminal Justice System[68]. The Prison Health Service is advised to work with other government organisations to develop data sharing systems which can be used to inform planning for health services for women in prison and PCTs are urged to provide supportive multi-disciplinary services to support the children of mothers in custody[67]. The Review of Women with Particular Vulnerabilities in the Criminal Justice System[68] recommends the establishment of a national Commission for Women who Offend or are at Risk of Offending which will direct and monitor local commissioning of integrated services and which will co-ordinate its work with the Department of Health to ensure the delivery of mental health services to women in prison.

Inspection and audit are identified as additional means of ensuring that services address both children's and adult's needs   In children's services, an integrated framework for the inspection of social care and education services was established under the Every Child Matters agenda[10]. Joint Area Reviews

(JARs) have been introduced for education, children's social care and young offenders' services in local authorities and one of their tasks is to monitor assessment arrangements across local services for children with additional needs[13,53]. The Royal College of Psychiatry identifies a series of questions which could be used to audit local need and service provision in relation to families where parents have mental health problems:

> • what proportion of adult patients are parents?
> • how many parents of referred children experience mental ill health?
> • are there visiting procedures for in-patients who have dependent children?
> • how frequently is the named doctor consulted?
> • is information provided routinely for children and young people about their parent's condition and treatment?
> • are clinic appointments and home visits scheduled at times which do not conflict with child care arrangements?
> • do side-effects of medication interfere with parenting tasks?
> • is there a prescribing policy for mothers who are pregnant or Breastfeeding? (p30[36]).

Similarly, the Implementation Guidance for Mainstreaming Gender[37] recommends reviewing provision of existing visiting facilities for children visiting parents in mental health units to ensure that they are child/family friendly. This review was undertaken by Barnardo's and the Mental Health Act Commission in 2006[174].

2.5.2 Assessment and Planning

There are numerous references in policy and guidance to the need for joint assessments and for one agency to involve another in assessments. However, this section focuses on the specifics of assessment and planning with families where parents have mental health problems rather than broad injunctions. The question of when to assess is an important one: the guidance on the Common Assessment Framework for Children and Young People raises the question of what might indicate the need for a common assessment and identifies parental mental health issues as one such trigger[15.] Parental mental health needs are one of the family and environment factors that practitioners undertaking an assessment under the Common Assessment Framework are alerted to[14]. The guidance on the Carers (Recognition and Services) Act 1995 notes that primary care staff who refer service users for a community care assessment should inform carers of their right to request an assessment[60] and this represents another way in which assessment might be initiated. The National Service Framework for Children[48] argues that early assessment and intervention is of particular value for children of parents with mental health problems and that parental mental health needs should be identified by a systematic assessment which is completed by a child's first birthday.

The Green Paper, Independence, Well-Being and Choice, on the future of adult social care emphasises that adults with mental health needs cannot be assessed in isolation from their families :

Adults with dementia, complex mental health problems or disabilities have a considerable impact on families, friends and carers. Only by taking account of their needs, the needs of the whole family and responsibilities of family members, including those for dependent children and young people, will it be possible to identify what services or interventions are needed (p31[65]).

The report envisages that 'skilled social work' (p32) will continue to be required for those assessments where complex problems have a significant impact on children and young people in the family and where risks need to be assessed[65].

Few references were found to models of assessment or planning which might be employed specifically with parents with mental health problems and their children. The Framework for the Assessment of Children in Need and their Families suggests that assessments with such families might be both joint and concurrent and acknowledges the need to examine the effect of the child on the parents as well as the impact of the parent's problem on the child:

> In some situations, where the parents' problems are severe, such as major psychiatric illness or substance misuse, there may need to be joint or concurrent assessments; to examine the parent's problems, the impact of those problems on the child, and the effect of the child on the parent. Such assessments should be carried out within a clear focus on the needs of the child (p25[4]).

The Framework[4] also provides practitioners with a series of tools for assessment which include standardised questionnaires such as the Parenting Daily Hassle Scale and the Adult Wellbeing Scale developed in research settings to assess mental health[3].

An alternative model for planning care is identified by the Social Exclusion Task Force Reaching Out review. The model draws on family strengths and focuses on the identification of signs of relapse:

> *Family Care Planning*
> This model of family-led planning has been used in Australia to help families cope with parental mental illness. It involves the whole family in drawing up coping strategies in case of crisis, in addition to a longer term plan identifying family strengths and aspirations. Often triggered by a crisis, the plan develops both formal and informal support networks and focuses on recognising early warning signs which could prevent situations from escalating. This approach brings about greater family discussion and understanding of mental health issues (p33[70]).

The guidance on the Carers Act 1995 emphasises the importance of recognising and managing conflict between different family members as part of the assessment process. The guidance suggests that two workers may be required to negotiate a resolution:

There may be differences of view between young carers and their parents which have not been expressed. Care managers will need to be alert to the possibility that children's worlds are largely determined by their parents and that children may feel that their views have no weight. Equally, they may be afraid that any admission of the difficulties may lead to a break up of the family. Such potential conflicts of views and interests may be very difficult to recognise and manage, especially for staff who have no experience of working with children. Arrangements may have to be made to ensure that the necessary range of skills and knowledge is made available to the whole family (p12[60]).

This guidance also provides a detailed checklist to be used when assessing a young carer:

When doing an assessment of a young carer:-
- Listen to the child or young person and respect their views
- Give time and privacy to children who may need this in order to talk about their situation
- Acknowledge that this is the way the family copes with the disability or illness of a family member
- Acknowledge parents' strengths
- Beware of undermining parenting capacity
- Consider what is needed to assist the parent in her/his parenting role
- What needs does the child(ren) have arising from caring responsibilities
- Consider whether the caring responsibilities are restricting the child's emotional and social development are being impaired
- REMEMBER children must be allowed to be children
- Provide information on the full range of relevant support services; any young carers' groups and contact points for further advice or information on specific issues (p12[61]).

Other recommended elements of an assessment include the importance of recording a detailed chronology when fabricated or induced illness in a child is suspected[6]. The Joint Chief Inspectors' Report on arrangements to safeguard children[5] found that the absence of chronologies and summaries in the broader sample of child protection work they surveyed led to delays and drift in the work undertaken with families.

The guidance also gives consideration to questions about which professionals should be involved in assessment. The Royal College of Psychiatrists[40] specifies the contribution of adult psychiatry to an assessment but distinguishes their contribution from an assessment of parenting itself. The report recommends that forensic psychiatrists or psychotherapists be involved in the assessment of personality disorder:

When requested, assessment of the parent should lead to a stated diagnosis, outline of the treatment required and its probable duration, and the likely prognosis. It also needs to address the impact of the parent's difficulties on their functioning, and in which areas this might be

relevant to their ability to meet the needs of their children. It should not be an assessment of parenting, which needs to include interactional assessments and other observations not usually within the brief of the adult psychiatrist (see below). In cases of personality disorder, it may be preferable for this assessment to be made by a forensic psychiatrist or psychotherapist (p26[40]).

The review also identified recommendations regarding the involvement of Child Protection staff in PCTs in the assessment of contact between mothers with mental health problems in prison and their children:

> The PCTs' role would be in supporting the Inreach and Prison Primary Care Teams in their assessments of the appropriateness of women's contact with their children, and the Child Protection Staff at the PCT liaising with the prison staff to offer advice on issues of concern, linking in with the Local Authority where required (p22[67]).

The link between assessment and planning is particularly emphasised in consideration of mothers' mental health problems in the context of maternity care. Midwives and obstetricians are encouraged to elicit any previous history of mental health problems early in pregnancy and to provide women with information which facilitates the disclosure of mental health issues[51]. For women who are identified as at risk of a recurrence of severe mental illness, professionals, together with the woman and her family, are advised to develop familiarity with her individual 'relapse signature' (p35[51]). A plan of care based on a structured assessment of needs which employs an identified assessment tool is required:

> *Post-natal Ongoing Community Care:*
> All PCPs involved in the care of women immediately following childbirth need to ensure that the care and support provided is tailored to meeting the individual needs of each woman. The mother's plan of care should be drawn up by the midwife or health visitor following a structured assessment of needs, using a recognised assessment tool and PCPs should be informed when there are particular problems. Post-birth care for the mother may need to be provided for 3 months, or longer, depending on need. All PCPs should be able to distinguish normal emotional and psychological changes from significant mental health problems and to refer women for support according to their needs (p44[50]).

As noted above, the Implementation Guidance for Mainstreaming Gender and Women's Health[37] advocates the use of care pathways to link maternity services to specialist mental health services and notes that care plans produced by mental health services should specifically address the risks in pregnancy.

An insistence on the provision of a care plan for both parents with mental health needs and children is discernible in the guidance. Maternity services are to provide ''a written plan of agreed multi-disciplinary interventions and action to

be taken' for all women identified as at risk of a recurrence of severe mental illness' (p35[51]) The White Paper on looked after children, which highlights parental mental health needs as a factor in children entering and remaining in the care system, requires all children who return home from care to have 'a Child in Need Plan which identifies areas in which parental capacity needs to be strengthened in order to safeguard the child on return home' (p42[21]).

2.5.3 Preventive Services and Service Thresholds

The preventive initiatives for parents with mental health problems and their children most frequently identified in this review involve what are often described as nurse adviser or home visiting services which focus on either the perinatal period or on families with pre-school children. Health visitors and school nurses are identified as having key roles to play in monitoring children's development and in identifying mental health problems in the perinatal period[4]. Targeted screening of mothers for mental health problems is recommended and the Audit Commission[2] flagged up a role for specialist mental health workers in training community based staff to undertake such work. The 2006 Green Paper on looked after children announced a number of pilot schemes for a preventive family support service delivered by midwives and health visitors[12]. The Family Nurse Partnership offers an intensive visiting programme targeted at disadvantaged families (including those with parental mental health needs) during pregnancy and in the first two years of a child's life[66]. More accessible primary care centres which include walk-in centres together with Sure Start Children's Centres are seen as a means of improving access to maternity care for 'hard to reach' groups[17]. Sure Start Children's Centres offer a range of interventions including one-to-one listening, home visits and group sessions to parents with mental health needs[19]. Other preventive services delivered in the perinatal period include *Brief Encounters*[177], a training package to enable health visitors to undertake relationship work with parents following a birth. The SEU report[41] argues that such relationship problems are associated with postnatal depression and views this initiative as having a preventive impact.

The Royal College of Psychiatrists flags up the possibility of undertaking 'secondary prevention':

> *Postnatal Depression*
> The detection of those at risk because of previous episodes, close monitoring, early detection and swift intervention will do much to minimise maternal morbidity and limit the adverse effects on the infant and family. Continuation during pregnancy of appropriate medication of women with chronic schizophrenia will reduce the risk of relapse before and after birth (p11[32]).

The voluntary sector, together with Sure Start and Early Years services, are seen as taking a key role in the provision of community based preventive services[37,54]. Health promotion and public health initiatives which provide families with information about mental health and relevant services are also identified as relevant to prevention[29,37,45,49].

High eligibility thresholds emerge as a key problem in delivering preventive and supportive services to parents with mental health problems and their children. The examples identified by the review mainly concern the high thresholds set by mental health services:

> ….each agency is restrained in its intervention by its own eligibility criteria. It may be possible for some families to have a range of problems, all of which fall just below eligibility thresholds, but which in combination present very significant risks….The wider needs within the family may not be dealt with until they reach the eligibility thresholds of individual services. This can hinder the ability of one agency to address the needs which it is presented with if another agency is not also working with the family. One example of this, highlighted in an area study, was of mental health services not working with an adult in the family as their needs were not deemed severe enough (p41-42[70]).

Likewise, The Review of Women with Particular Vulnerabilities in the Criminal Justice System[68] notes that many women in prison have lower–level mental health problems such as personality disorder which do not qualify them for a psychiatric bed[68] .

However, the Royal College of Psychiatrists[40] identifies that, while parental mental health problems may have a negative impact on a child, this will not necessarily meet the threshold for significant harm. The SEU report[41] takes a fair-handed approach and highlights the difficulty in accessing mental health services prior to a crisis while noting that children's services can focus more on assessing contribution of parental capacity to child protection than on providing support.

2.5.4 Interventions for Parents with Mental Health Problems and their Children

As noted in relation to preventive services, the voluntary sector is seen as playing a substantial role in the provision of direct supportive services for families. The work of Building Bridges, Homestart, NEWpin, The National Childbirth Trust and the Association for Postnatal Mental Illness, well as that of Sure Start Children's Centres, is cited in a number of reports. The Reaching Out Plan[66] identifies the ability of Family Intervention projects which offer a range of interventions from home visits to residential stays to engage with families where parents have mental health problems. Again, this initiative is delivered by the voluntary sector. Positive Steps: Supporting Race Equality in Mental Healthcare[45] describes the work of Oppressed Voices, a community based initiative for South Asian women, which has raised awareness concerning this group's experience of domestic impact and its impact on women's mental health. Other initiatives targeted on Black and ethnic minority groups include Community Mothers, volunteers trained to provide support and befriending to new mothers[19]. The SEU report[41] argues for increased access to education, volunteering and arts opportunities as a means of enabling parents with mental health problems to engage with their local community and increase

their social contacts. While some agencies providing such opportunities will be mainstream organisations, many will be located in the voluntary sector.

Both the Royal College of Psychiatrists[32] and The Women's Mental Health Strategy[35] argue for increased provision of specialist mother and baby units. The guidance on commissioning women-only community day services offers the options of either commissioning such services from the voluntary sector or reconfiguring existing provision[42]. The guidance identifies a range of interventions which might be offered by such services including parenting support, child care, drop-in facilities, self-help groups and crisis services and identifies the key characteristics of a women-only service. The guidance also suggests that women with mental health needs could make use of direct payments to purchase services such as childcare and other forms of support[42]. Guidance on direct payments issued in 2003 notes that the local authority may be able to use direct payments to support parents with mental health needs bringing up their children and provides a case study of the use of direct payments to support the parenting of a mother with severe mental health problems (p31[63]).
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The *Code of Practice*[31] for the Mental Health Act 1983[46] included guidance on children visiting patients in hospital. References to children visiting parents in mental health units found by the review were mainly concerned to invoke the relevant guidance which stresses the need for such visits to be in accordance with written policies[31]. However, the SEU report[41] notes that facilities are needed to support children's contact with parents during in-patient stays. Services to provide support for maintaining contact between women prisoners and their children are proposed by the Women at Risk report[67] and the Corston Report[68]. It is suggested that such services should be commissioned by the prison service from the voluntary sector. The needs of children whose mother is in custody are also flagged up by the Women at Risk report[67] which suggests that health visitors and school nurses should offer support to such children.

The review found evidence of increasing interest in the development of reunification services for parents with mental health problems whose children return home from care. The need for such services was first flagged up by the guidance on Safeguarding Children in whom Illness is Fabricated[6] but it is picked up in the recent White Paper on looked after children[21]. This policy document also highlights parents' needs for tailored packages of support and short term breaks (p30[21]).

2.5.5 Integrated Planning and Services

The gaps between children's and adults' services have been a consistent theme of this review and some specific proposals for developing more integrated services for parents with mental health problems and their children were identified. The gaps to be addressed are not just those between children's services and adult mental health services but also those between child and adolescent mental health services (CAMHS) and adults' mental health services[2]. The Children Act 1989 report[17] noted that one of the key features required of Children's Trusts were:

Arrangements for addressing interface issues with other services, such as services for parents with mental health problems[17].

The Royal College of Psychiatrists recommends using designated sessions to create liaison posts or using secondment arrangements to close the gaps between adults' and children's mental health services[36]. The Social Exclusion Task Force (2007) describes 'semi-located teams':

> ….workers form a team supporting families as part of their job but also remain part of their host agency. They are thus able to maintain their professional specialist skills and link into networks in their host agency, whilst also working with staff from other agencies to support families. Co-location and 'one-stop shop' approaches are also leading to better integrated services (p41[70]).

'A community-based multi-disciplinary/multiagency perinatal mental health service working in partnership with local communities to build capacity for early identification, support and treatment' is also advocated by the Women's Mental Health Strategy document (p87[35]).

At the local level, the introduction of Local Safeguarding Children Boards[9] which replace the Area Child Protection Committees provides an interagency structure for planning children's services. Although health and social care mental health services have been brought together in Mental Health Trusts, no comparable interagency planning forum exists for mental health services despite the fact that services to support people with mental health needs are increasingly broadly defined and various. The review identified proposals for strategies and protocols to address perinatal mental health[32,35] but these services currently remain firmly within the health sector.

2.6 Conclusions to the Review of Policy

The following points emerge from this review:

- Much of the policy and guidance reviewed here remains preoccupied with identifying the associations between parental mental health problems and children's welfare. There is increasing recognition of the gaps between children's and adults' services and the fact that these gaps do not reflect the extent to which children's and adults' needs are interlinked. Professionals and services are exhorted to interact in ways that reflect the interaction of the needs of family members.

- While the bulk of policy and guidance aimed at explicating the links between parental mental health problems and child welfare focuses on the impact of parental mental health on children, there is some recognition in recent publications that the demands of parenting, particularly when parenting is undertaken under adverse conditions, may contribute to parents' mental health problems.

- Most of the policy injunctions to develop a family focus or look beyond service divides appear to be directed at practitioners and managers in mental health services. This reflects research and other literature in the field which emphasise that mental health professionals often fail to recognise service users' roles as parents. However, there may be a case for policy to identify and make use of the research evidence which examines the capacity of practitioners in children's services to identify and respond appropriately to manifestations of mental illness in parents[138,176,185].

- Law, policy and guidance in this field explicitly prioritise the needs of and risks to children. Concerns about risks to children appear to be the strongest driver for interagency communication, collaboration and integration and these concerns have exerted a discernible influence on the pattern of development of planning and service structures.

- Policy and guidance tend to utilise the concept of '*parental* mental health problems' rather than differentiating between mothers' and fathers' mental health needs. Whilst mothers' mental health problems are highlighted in relation to perinatal disorders and the risks these present for children and in policy addressing women prisoners, fathers with mental health problems receive very little attention. Even guidance on the risks presented by adult offenders fails to specifically mention fathers[25]. This is surprising given the preoccupation with risks for children and the fact that men may represent a source of such risks. This finding resonates with that of the SCIE Knowledge Review, *Supporting disabled parents and parents with additional support needs*[163] which found that men's parenting roles went unacknowledged within adult social care policy.

- Likewise, despite the considerable body of evidence concerning the experience of mental health needs and mental health services among different minority ethnic groups[156,173], there was little in the policy or guidance reviewed (with the exception of the Supporting Race Equality report[45]) concerning the ethnicity of families where parents have mental health problems.

- Particular groups such as 'young carers', 'parents who fabricate or induce illness', or 'women prisoners' have attracted the attention of policy makers and a commitment to meeting the needs of these groups has the effect of focusing interest on the interface between mental health and children's services.

- A focus on risk in children's services appears to have provided a strong mandate for the development of structures to facilitate interagency planning and service delivery within children's services. A similar, although less developed, structure is identified in the Care Programme Approach (CPA) in mental health services. While these structures offer potential for collaboration and co-ordination between children's and adult

mental health services, such links are not the primary aim of such structures: the SCIE Knowledge Review, Supporting disabled parents and parents with additional support needs[163] points out that the Every Child Matters agenda focuses on interagency communication and collaboration between children's social care, child health and education rather than between children's and adults' services. There are therefore no built-in devices for linking the CPA with the CAF. Using these structures to facilitate collaboration between adult mental health and children's services would require their primary remit to be extended or refocused.

- A range of approaches aimed at improving interagency communication, collaboration and at achieving integration were identified by the review. However, the issue of varying thresholds for eligibility to services remains unresolved and is likely to represent a barrier to developing preventive services and may render attempts to establish structures such as care pathways problematic.

- The perinatal period is identified as a period with both the potential for delivering preventive or early interventions to families where parents have mental health problems and a period when risks to children are high because of their vulnerability. There is therefore a double imperative for the development of collaborative structures between maternity services, children's services and mental health services. In some areas, Sure Start Children's Centres are seen to offer a setting for delivering such integrated services.

- The policy and guidance reviewed highlights the provision of a range of family support services targeted on families where parents have mental health needs by the voluntary sector and by Sure Start Children's Centres. Policy gives limited consideration as to how such services co-ordinate their activities and make links with statutory mental health and children's services. It is unclear whether such organisations are conceptualised as targeting a population whose needs are less severe or whether their role is conceived as providing a family focused mental health service in the absence of such a statutory service.

- Together with the women's mental health policy drive, the social exclusion agenda has succeeded in drawing attention to the relationship between children's and adults' needs and has emphasised that the relationship between parents' and children's need is not exclusively one-way. Conceptualising parents' mental health needs as at least in part a response to the demands of parenting under adverse conditions allows for the emergence of new responses, such as short breaks for parents under stress[21].

- The women's mental health strategy and the social exclusion agenda have also sought to develop a broader, more social model of mental health need and the range of services which might meet it. In doing so, they have drawn attention to the ways in which gender and ethnicity

structure mental health need as well as access to and experience of services. The recent introduction of the public Equality Duties is identified as a driver for ensuring that the impact of these factors on health and social care service delivery is more openly acknowledged and that inequalities in service outcomes for different groups are addressed[42]. For parents with mental health problems and their children, this may mean focusing attention on how service outcomes for this group are shaped by mental health problems since the public Equality Duty in respect of disability includes mental health difficulties.

Table 2 below summarises the key policy drivers for intervening to support parents with mental health needs and their children. Table 3 identifies the key policy gaps and barriers identified by this review.

Table 2: Messages from Policy to Support Work with Parents with Mental Health Needs and their Children

Key Message	Source
Commissioning of maternity services to include provision for parents with mental health needs	NSF for Children and Maternity Services 2004
All local authorities, health trusts, health authorities and criminal justice organisations to have 'regard to the need to safeguard and promote the welfare of children' in	Section 11, Children Act 2004

discharging their functions	
All local authorities, health trusts, health authorities and criminal justice organisations to provide staff with statement of agency's responsibilities to children and establish clear line of accountability for work on safeguarding children and promoting their welfare.	Statutory Guidance on Making Arrangements to Safeguard and Promote the Welfare of Children 2007
Staff in mental	Working

health, health and adult social care services have a responsibility to safeguard a child at risk of harm and should activate local safeguarding procedures	Together 2006
Parenting roles and responsibilities come within the criteria for adult social care services	FACS Practice Guidance 2003
Tools to facilitate information sharing	Every Child Matters (Green Paper) 2003

between services about children – CAF, ContactPoint

Where there is risk of significant harm to a child, confidentiality can be breached without parents' permission

Information Sharing: Practitioners' Guide 2006

Lead professional to co-ordinate services for children and families and act as contact point

Statutory Guidance on Making Arrangements to Safeguard and Promote the Welfare of Children 2007

The adult's

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identity as a parent should be recorded and addressed at every stage of the assessment, care planning and review process as should the needs of the wider family.

Programme Approach 2006 (to be included in 2008 final version)

Parental mental health needs constitute a trigger for using Common Assessment Framework

Common assessment framework for children and young people 2006

Staff in

NSF for

maternity services to identify women's mental health needs in pregnancy	Children, Young People and Maternity Services 2004
Young carers have a right to be offered a carer's assessment by adult social care services and may be offered direct payments	Carers (Recognition and Services) Act 1995 Direct Payments Guidance 2003
Direct payments can be used to support parents with mental health needs	Direct Payments Guidance 2003

bring up their children	
Maternity services to provide a written plan for all women at risk of recurrence of severe mental illness	NSF for Children, Young People and Maternity Services 2004
Tailored packages of support and short-term breaks to be made available to families where parents have mental health needs	Care Matters: Time for Change (White Paper) 2007
Services to support	Care Matters: Time for

reunification process for families where parents have mental health needs and children are returning home after being looked after	Change (White Paper) 2007
Health visitors and school nurses to take preventive role in identifying mental health problems in perinatal period	NSF for Children, Young People and Maternity Services 2004
Family Nurse Partnership piloted - intensive visiting	Care matters: Transforming the lives of children and young people in

programme targeted at families with parental mental health needs during pregnancy and in the first two years of a child's life

care (Green Paper) 2006

Table 3: Policy Gaps and Barriers Identified by the Review

- Mental health services lack an interagency forum for co-ordinating the planning and work of local agencies at a senior level comparable to the function of LSCBs

- Policy rarely acknowledges conflicting models of mental health need and tends to conceptualise the relationship between parental mental health needs and children's needs as one-way, ie. parent to child

- Policy addressing parents with mental health needs neglects the role of fathers

- Risks to children remain the strongest mandate for interagency work with families where parents have mental health need, the mandate does not operate in the absence of risk

- Women in prison have limited access to mental health services

- Systems to share information and co-ordinate assessment introduced by Every Child Matters focus on children's social care, education and child health services. The contribution/role of adult social care and mental health services to such systems is unclear

- Parents in hospital and women in prison lack access to services to support contact with children

- The high thresholds set by children's, adults' and mental health services constitute a barrier to the provision of preventive and support services for families where parents have mental health needs

- No mechanisms or systems to link the CPA with the CAF or Framework for the Assessment of Children and their Families

- AMHPs currently lack a clear

mandate to assess and make appropriate provision for children's needs – this may be provided by the Code of practice on the Mental Health Act 2007 due to be published later in 2008.

- There is a lack of structures/systems specifically for evaluating access to services for families where parents have mental health needs

Chapter 3: Users' and Carers' Perspectives on Professional Education for Work with Parents with Mental Health Problems and their Children

3.1 The Consultation

The service users and carers interviewed for this consultation have on-going involvement with the Comensus project at the University of Central Lancashire; some are members of other groups of users and/or carers. The six users and carers were recruited to this review on the basis of their experience of families where parents or children have mental health needs. They include adults who grew up with family members with mental health difficulties, parents with mental health needs and parents with mental health needs whose children also experience mental health difficulties. They have between them considerable experience of contributing to teaching on health and social care programmes, some are members of university departmental and faculty committees, some are involved in research and some are active in carer and other support groups, some all four. Their lived experience together with the knowledge and understanding they have acquired in the field of professional education confers the status of 'expert users'[154,162] on this group. The group's ages range from 20 to 60, it includes women and men and and representatives of different minority ethnic groups. In order to maintain confidentiality, individuals are identified by initials only (not their own) which are used throughout.

The service users and carers contributing to this review were clear that service providers and practitioners needed to understand the issues for both parents and children when parents have mental health problems. They described experiences of services focusing on one family member to the detriment of the others and they wanted services to acknowledge and respond to the needs of both parents and children. They considered that, if services were to change, professionals needed a very different sort of education to that currently provided. They offered ideas about how change could be brought about, and how they could help to make it happen.

3.2 Knowledge and Skills Required for Work with Parents with Mental Health Problems and their Children

The users and carers consulted felt that generally professionals lacked essential knowledge and understanding about parents with mental health needs and their children. They considered that, at present, many professionals were insufficiently knowledgeable about mental health:

> KL: Not enough is taught about mental health, all professionals should be taught more about it. Many people have mental health issues and professionals should be educated: there's so much ignorance surrounding mental health. [Professionals] should also be taught that children can have mental health problems….people still believe children can't have mental health problems.

Social workers who worked with children were considered to have little understanding of mental health issues and it was noted that this also applied to teachers. It was felt that even health professionals, such as GPs, could improve their knowledge of mental health issues. Service users and carers also noted that more research was needed about the mental health of minority ethnic groups in order to inform practice and that practitioners needed to have access to knowledge relevant for work with refugee and asylum seeking families.

Users and carers consulted felt that it was particularly important for professionals to understand the impact that parental mental health problems could have on children and noted that such needs could affect children's learning, emotions and behaviour in school:

> EF: [It's important] to recognise the trauma for children, especially if a parent has personality disorder and has very different moods.

They commented that older siblings might be caring for younger ones which would impact on their education. As well as considering how parents' needs impact on children, practitioners needed to take account of how children's needs affected parents:

> IJ: Parents with mental health problems impact on children – and vice versa.

They argued that professional education in this field needed to take the family as its focus:

> EF: More education is needed about mental health with the family – children and elderly people, especially teenagers.

> IJ: [In teaching] there needs to be awareness of the whole family.

However, professional education needed to distinguish between the varying needs of different family members:

> IJ: a proper understanding and knowledge about how things can be different for each family member, including differences among siblings.

The users and carers consulted also emphasised that professional education needed to address the issue of how practitioners communicated with service users and carers:

> KL.:[All professionals] need to learn better communication skills….

It was considered particularly important that health and social care practitioners took the trouble to communicate clearly and fully with children in families where parents had mental health problems:

> IJ: Professionals should listen to and respect children's contribution, as well as adults.

The need for teaching on confidentiality was mentioned as it was considered that barriers between professionals and families could stem from misunderstandings in this area. Those consulted also identified the need for improved communication and co-ordination between different professionals and suggested that these skills could be developed through professional education.

> EF: Social workers and GPs and the psychiatrist should work with the family together

> GH: A need for case meetings to include all disciplines and the service user and their families. Doctors and psychiatrists need to be educated as to how to be in those meetings and facilitate them without dominating.

3.3 Recruitment, Programme Structure and Staffing

Recruitment processes for qualifying programmes were seen as an important aspect of producing appropriately skilled practitioners:

> IJ: [Programmes] can teach communication but have to recruit people with the skills to use it: need to recruit [students] with an aptitude for communicating..,

The need to recruit students with appropriate attitudes was also emphasised.

Users and carers also commented on the skills and background of staff delivering professional education and noted the value of a diverse workforce:

> CD: [Universities should] continue to employ black and minority ethnic lecturers.

There was also interest expressed in developing interprofessional opportunities for professional learning and placements were identified as one setting where this could happen relatively easily:

> EF: If it was possible for GPs, social workers, junior doctors to train together – on placement with one another and in school settings…..If training was brought together under one umbrella it could help.

3.4 Learning Approaches

The users and carers consulted emphasised the need for learning that was experiential or which valued life experiences:

> AB: More about people's experiences – reading and talking about life experiences… need to develop empathy.

> IJ: Some practical experience: give all students (all professions) the experience of being a carer for two weeks as part of their training. They

need to understand what caring in communities is actually like – and it would give carers a respite…

The value of involving service users who had relevant experience of parental mental health problems in professional education was stressed:

> KL: Involve families in courses, talking about what it's like, why support groups are needed and what has been achieved.

Some professional groups were considered more ready to involve service users in professional education than others:

> GH: Look at doctors and psychiatrists – their professional bodies are better than they used to be, but there are time barriers [against getting involved in teaching them]….usually they're pressed for time…but doctors and psychiatrists make most of the decisions..[we need]…. to get in on the ground floor while they're training…

However, it was noted that user and carer involvement in professional education could be tokenistic and this user/carer argued that service user involvement needed to extend beyond contributing to teaching and that the experience of users and carers should provide the foundation for the design and content of professional education:

> GH: Professional education is based on what's in policy documents – should be based on service user experience and service users' participation should be central.

3.5 Future Developments

While the users and carers consulted as part of this review felt that both professional education and practice could be described as generally improving and identified evidence that both were attempting to be more responsive to service users' needs, they stressed that professional education on parental mental health and child welfare 'is ongoing and improving, but not yet one hundred per cent'. They argued that education on parental mental health and child welfare 'should be a strand in all health related courses' and one service user and carer expressed the hope that 'this review might do something (to get) more support on courses'(AB).

3.6 Conclusion to Users' and Carers' Consultation

The users and carers who contributed to this consultation were an expert group who offered both lived knowledge of the issues of parental mental health and child welfare and experience of contributing to and commenting on professional education in health and social care. Some of their suggestions resonate with those of the users and carers whose views contributed to the 2007 consultation on the roles and tasks of social workers[140].

They noted the need for more education on mental health for all professional groups and wanted understandings of the impact of parental mental health on children to take account of children's experiences outside the home and of the differential effects of parental problems according to children's age and development. They also commented that professionals needed to recognise that, as well as parents' problem impacting on children, children's needs and problems affected parents. They argued that professional education should take the family as its focus.

The service users and carers consulted emphasised the importance of professionals developing good communication skills and an understanding of how to manage confidentiality. Interprofessional learning was seen as one way of developing necessary skills in interprofessional work.

Not surprisingly, the users and carers emphasised the value of incorporating users' and carers' view into professional education and noted that some professional programmes were achieving this in a more consistent and meaningful way than others. Accounts of user and carer involvement in professional education highlight the need for planning and resources to facilitate such involvement and for power imbalances between professionals and/or programme providers and service users to be acknowledged[135,136]. Generally, the users and carers consulted considered that there was much more to be done in educating professionals about parental mental health and child welfare and that the issue needed to be addressed on the full range of professional programmes.

Chapter 4:   Review of Professional Education

4.1 Context for the Review of Professional Education

This review is influenced by a number of factors and events occurring around the start of the 21st century. The inquiry into the death of Victoria Climbié[157] highlighted the lack of interprofessional communication and collaboration between services working with children and their families, echoing findings from the previous 25 years[182]. The government's modernisation agenda, as articulated in the National Service Framework (NSF) for Children[47] and the National Service Framework (NSF) for Mental Health[29] emphasised the need for workforce development to be directed by policy goals, so identifying educational agendas broader than those of the professional bodies. In addition, health and social services began to respond to the government drive to promote service user and carer involvement in commissioning and planning health and social care services[98]. Service users' views and wishes were identified as key elements which should inform front-line professionals' interactions with service users[55], and this is now enshrined in the basic principles of the Mental Health Act 2007[46]. Higher education institutions (HEIs) also began to move towards involving service users and carers in teaching, research and other scholarly activities[79,139,158].

The outcomes of the foregoing include a wider acknowledgement at the policy level of the significance of links between services, and the necessity of interprofessional communication, especially for those practitioners working with parents and children; recognition of the expertise of users and carers and their contribution to both service delivery and professional education and a developing role for the higher education (HE) sector in professional education[150]. Student numbers on pre-qualifying and pre-registration professional programmes have increased in line with an expanding health and social work services, although this trend has seen recent checks in the form of a reduction in the numbers of fully funded places on the midwifery degree programmes[148] and a drop in the number of posts available for qualified nurses and other health professionals[144].

These developments have led the professions of social work, nursing, midwifery, health visiting, occupational therapy, general practice, psychiatry and psychology to revisit the ways in which they have recruited and educated their members. A number of the professional bodies have reviewed and developed, or are in the process of reviewing and developing, criteria for knowledge, skills and practice competencies (and sometimes also values) for professional education. In line with the HE 'widening access' agenda, both midwifery education and social work education have introduced undergraduate routes which have been aimed at boosting recruitment and reducing the age of entry to these professions. At the time of writing, clinical psychology education is implementing changes to its entry level programmes and nursing is revising its post-qualifying curricula. Prompted by the government's emphasis on workforce planning, the professional bodies are also considering what skills and knowledge will be needed by health and social care practitioners in the future.

The review of policy presented in Chapter 2 of this report found numerous references to training and education as the mechanisms for enabling practitioners to 'look out of the box' and for offering more integrated services to families where parents have mental health needs. The Royal College of Psychiatrists (RCP) identifies child protection training as 'an essential component 'of the training of child and adolescent psychiatrists (p25[40]). The NSF for Children proposes that service users contribute to the development of local interprofessional training programmes aimed at developing skills in supporting parenting when adults have mental health problems[48]. The NSF for Children also advocates education and training in recognising and responding to the mental health needs of children and their families for all children's health care staff in hospital services[101]. Policy documents on women's mental health recommend that the full range of professionals involved in work with mothers with mental health problems receive education on perinatal mental health issues[32,37]. The government announced in 2004 that:

> DfES will work with DH to ensure that the common core of training for professionals working with children and families addresses mental health issues (p105[41]).

This review will seek to establish the extent to which professional education bodies and workforce strategies acknowledge a need for professional learning to address the linked issues of parental mental health and child welfare. It will also identify those elements in professional education standards and requirements that contribute to the development of knowledge, values and skills relevant to work in this area. A large number of professional groups are covered by this review - social work, community psychiatric nursing, midwifery, health visiting, occupational therapy, general practice, child and adult psychiatry and clinical psychology – so in order to limit the scope of the review a tight focus on the linked issues of parental mental health and child welfare is maintained. However, the issue of professional education for interprofessional work and communication is very germane to the topic of the review and broader, less specific, material on this theme will be included.

4.2 Professional Bodies – Guidance and Curricula

The professional bodies take a common approach to determining the content of qualifying curricula, relying on specifying learning outcomes in the form of competencies. The details of the curricula are left to the discretion of higher education institutions (HEI) programme providers, although programmes have to fit both the professional bodies' requirements and national occupational standards. Programmes are subject to review at both local and national levels. The degree of specialisation available within professional education is relevant for this review and specialisation is introduced at different levels in different professions. In nursing, for example, broad specialisms are introduced at the pre-qualifying level following a foundation year, while in social work, they are found at the post-qualifying level. While all professionals are required to undertake Continuing Professional Development (CPD), the content of such learning is usually unspecified with practitioners in nursing, psychology and other professions being directed to construct their own learning routes.

Professionals are required to complete a specified number of learning hours to maintain professional registration, but in CPD the emphasis is on self-directed and self-planned learning.

In social work education, pre-qualifying education remains generic and students graduate (in theory at least) qualified to work with any user group. Many social work programmes devote separate modules to teaching mental health and work with children and families although opportunities exist within such modules for the links between parental mental health and child welfare to be made. At the post-qualification level, social work education separates children and mental health into two different pathways. However, the standards for these two pathways do identify the need for those undertaking a mental health pathway to recognise the significance of parental mental health problems for children's welfare[85] and for those on a children's pathway to develop knowledge and skills in relation to parental mental health and its impact on children[83].

Clinical psychology programmes are also accredited against core competencies. The British Psychological Society's (BPS) criteria for qualifying clinical psychology programmes in the UK have recently been the subject of internal consultation and, at the time of writing, it is anticipated that the revised criteria will be approved and implemented within the next 12 months.Continuing professional development (CPD) for clinical psychologists' key roles is measured against competencies specified in *National Occupational Standards for Psychologists*[110]. Relevant post-qualifying material for clinical psychologists includes a position paper on child protection[114].

At the pre-registration level, nurse education includes a generic foundation year before diverging into four specialist pathways of which mental health and children's nursing comprise two branches. Thereafter, crossovers are only possible at post-registration level. The Nursing and Midwifery Council (NMC) plans to review the current *Standards for Specialist Education and Practice* which apply to all those qualifying in community mental health nursing, mental health nursing and community child nursing[122]. The NMC also intends to review the standards for advanced and specialist practice[122,124]. The Chief Nursing Officer's review of the nursing contribution to the care of vulnerable children[119] emphasised the need for improved skills in work with vulnerable families in both the antenatal and early postnatal periods.

The framework for undergraduate medical education for doctors is established by the General Medical Council (GMC) and the report, *Tomorrow's Doctors*[102], articulates current policy which is interpreted at the local level by medical schools. GP education is located at the postgraduate level and the new curriculum is the responsibility of the Royal College of General Practitioners (RCGP). The RCGP is at the time of writing piloting their own child protection module for GPs . At the level of undergraduate medical education, the medical schools have produced a position paper supporting the introduction of interprofessional modules or programmes[100].

Psychiatry is also a postgraduate branch of study in medicine. A revised curriculum has been proposed for psychiatric training following the publication of the report, *Mental Health: New ways of working for everyone* [78]; the evaluation of this new curriculum is being considered by the Royal College of Psychiatrists (RCP).

Pre-registration occupational therapy programmes in the UK are approved and reviewed by the Health Professions Council (HPC). Programmes undergo voluntary accreditation by the College of Occupational Therapists (COT) [130].

4.3 Overview of the Review

The review of guidance on professional education found relatively little material which directly addressed the skills or knowledge required for work with parents with mental health problems and their children. Much of the material identified which did deal with the relationship between parental mental health and child welfare concerned aspirations for practice rather than particular skills which might prepare practitioners to work across the two fields. Where the review did find professional education material which recognised the necessity for practitioners to develop knowledge of and act on the associations between parental mental health and child welfare, there was relatively little consideration given to how this might be embedded in professional curricula. Indeed, a separation between learning in mental health and learning in child welfare still seemed to characterise much professional education at both the pre-qualifying and post-qualifying levels.

This review of guidance on professional education has drawn on some relevant material on workforce planning. However, such publications may originate outside the professional bodies which control and manage professional education and it is not always clear to what extent the aspirations expressed for professional education in such documents are congruent with other aims and imperatives in professional education. Relevant quality assurance documents relating to professional education were also searched. However, many of these failed to yield references to parental mental health or child welfare and are therefore included in Appendix 2.

The review of the literature and guidance on professional education follows. The review is structured around the analytic framework shown in Appendix 3 but, where the material identified in relation to a sub-theme was limited, some sub-themes in the analytic framework are reported together under a single sub-heading. The structure of the review of policy and guidance on professional education is as follows:

1. Understandings of the relationship between parental mental health and child welfare

2. Developing practitioners' skills in thinking and acting 'out of the box': recognising multiple needs and communicating and working across service divides

3. Interprofessional education

4. Skills and approaches in working with parents with mental health problems and their children

5. Training materials

6. Reaching across roles and specialisms

4.4 Understandings of the Relationship between Parental Mental Health and Child Welfare

With the exception of General Social Care Council (GSCC) guidance which identified 'a range of models of mental disorder' (p22[85]), most of the material on professional education searched did not acknowledge varying definitions of mental health problems or disorders. This approach is consistent with that found in the review of policy in Chapter 2. However, guidance on professional education issued by the GSCC, Royal College of Psychiatrists (RCP), The British Psychological Society (BPS) and the Royal College of General Practitioners (RCGP) was found to include recognition of the interconnections between parental mental health and child welfare. The GSCC specifies that, in order to make informed decisions, mental health social workers need to:

> • have critical understanding of a range of models of mental disorder, including the contribution of social factors;
> • have critical understanding of the implications of mental disorder for service users, children, families and carers;
> • have critical understanding of the implications of a range of relevant treatments and interventions for service users, children, families and carers (p22[85]).

The knowledge required by a qualified child and adolescent psychiatrist includes:

> knowledge of the assessment and treatment of children and adolescents, knowledge of disorders that are usually first diagnosed in infancy, childhood or adolescence and developmental disabilities. In particular:
>
> a) The effects of adult mental illness on children. The effect of depression and other psychiatric symptomatology on parental functioning, and the impact of this on child development and functioning. An understanding of cultural variations in aetiology and management (p3[94]).

For GPs, a comprehensive approach in work with children and young people requires them to:

- Describe the needs of children of parents with substance misuse, mental health or domestic violence problems, teenage mothers and those with severe chronic or short-term conditions that affect their capacity to parent their children; some may need referral for multi-agency assessment and support services:
- this may include referral to the health visitor for a comprehensive family needs assessment to understand and address the impact of the parent's needs on the children's health and development (p15[105]).

In contrast, a recent publication[133] outlining a future strategy for occupational therapy in mental health services did not include consideration of the relationship between parental mental health and child welfare.

4.4.1 Impact of Parental Mental Health Problems on Children

Where guidance on professional education noted the significance of the relationship between parental mental health and child welfare, the review also found reference to the potentially damaging effects of parental mental health problems on children, including the risk of abuse and neglect. A report addressing the relevance of mental health learning at qualifying and postqualifying levels in social work education notes that:

Relevance of mental health learning for all social workers
- Parental mental health is one the most common factors associated with child protection registrations
- Government is actively considering the promotion of 'whole family' approaches to 'families at risk' – and mental health is one of key identified factors (p4[183]).

The BPS's *Child Protection Portfolio* draws attention to:

Recent evidence concerning impact of mental health problems on parenting
Many parents with mental health problems are able to parent well. However, there is evidence that mental health problems may be associated with a higher risk of child abuse (Reder & Duncan, 1999). At the extreme end of the continuum, 200–300 children in the general population die from abuse in the UK per year: of those that kill their children, a significant minority suffer with severe mental illness (Falkov, 1996; Reder & Duncan 1999) (p110[113]).

Guidance in professional education for both mental health social workers and mental health nurses alerts them to the risks for children when parents have mental health problems. The *Chief Nursing Officer's Review of Mental Health Nursing*[123] recommends that mental health nurses' assessments of risk to children should be informed by advice from designated child protection professionals.

In educational guidance for health visitors and school nurses, parental mental health problems are conceptualised primarily as women's mental health needs in the perinatal period and practitioners' role in the early identification of families 'at risk' is emphasised[115].

The potential for mental health problems to emerge in children and young people whose parents have mental health needs is emphasised in the BPS's child protection portfolio:

> Less extreme are the cases of adult mental health clients who may find aspects of parenting a struggle because of the symptoms they are suffering. Children in such families may be rendered vulnerable to problems with attachment, understanding what is happening and emotional disturbance (Duncan & Reder, 2000) (p110[113]).

However, the same child protection portfolio acknowledges that not enough is known about the effects of parental mental health needs:

> There is evidence that children of parents with mental health problems are at higher risk (40–60 per cent) of developing mental health problems in later life (Beardslee *et al*., 1998). Research has tended to focus on maternal mental illness, and its impact on the parenting of small infants (Oyserman *et al*., 2000). There have been few studies of the impact on care of adolescents, and little attention paid to the long-term assessment of risk across time and developmental phases (Oyserman *et al*., 2000) (p110[113]).

Some of the educational material reviewed emphasised high risks in relation to the children of parents with mental health problems. The BPS child protection portfolio notes that 'Mental illness or failure to take prescribed medication can cause parents/carers to behave in bizarre or violent ways towards their children' (p23[113]) and cites Falkov's 1996 review of child deaths[151]. The Chief Nursing Officer's review[123] stresses that nurses need to take action if they consider that a child is at risk in a family where parents have mental health needs.

The importance of professionals being alert to the presence of young carers of parents with mental health needs is noted in professional education guidance and in workforce reports for mental health nursing and for psychiatrists[61,85,92,94,113,123]. Educational material and standards issued by the RCP, the BPS and the GSCC all draw attention to the emotional, social and educational difficulties experienced by young carers[61,85,94,113]. *New Ways of Working for Psychiatrists* argues the need for practitioners to both identify young carers and to acknowledge how caring may affect their development; the report emphasises the costs of young caring to wider society:

> It is even more important that statutory services and other agencies remember the whole family; in particular the children who are young carers. Services must be provided for developing children and their

parents. The cost to society and the harm done to the individual when they are ignored is great (p45[92]).

Searches revealed little professional education material or guidance which addressed the concept of resilience, associated with protecting children from the impact of adversity. Given the prominence of work on resilience in child and family social work in recent years[149,153], it was surprising that no references to resilience in the face of parental mental health need were found in guidance on social work education. However, RCP guidance does highlight the role of resilience:

> Individual temperamental differences and their impact on parent-child relationships. Origins, typologies and stability of temperament and the evolution of character and personality. Childhood vulnerability and resilience with respect to mental health (p5[94]).

4.4.2 Parents and Gender

While the professional education guidance and material in social work, psychiatry, psychology and for GPs focused on *parental* mental health, guidance addressing nursing, midwifery and health visiting education[57] was more likely to emphasise maternal mental health. Although childbirth was identified in such documents as the context for maternal mental health problems, the review found little consideration of the ways in which caring responsibilities might contribute to mothers' mental health problems. In this review, the RCGP was unique in identifying 'demanding child care' as a contributory factor in women's depression[108] and its curriculum statement on women's health draws attention to women's role in caring for dependents as well as GPs' responsibilities for recognising domestic violence and its effects on women's mental health[106].

As was found in the review of policy in this field (see Chapter 2 of this report), few documents made specific mention of fathers. However, the RCGP curriculum statement on the *Care of Children and Young People* argues that the role of fathers in parenting is frequently overlooked and that all GPs should be able to support fathers and have skills for engaging with fathers as well as mothers[105]. In addition, the RCGP identifies the need for GPs to have knowledge of mental health conditions specific to men, including depression, suicide and andropause[107]. The *Facing the Future* review of the role of health visitors also notes the need to support fathers in their parenting role[57.].

4.4.3 Parenting Capacity

The impact of mental health on parenting capacity is emphasised in both professional education and workforce guidance documents. The interim report, New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context, asserts:

The importance of providing good input to support adults in parenting their children effectively is well established. Not only is this an important matter for the recovery of the adults concerned but the benefits to their children and the risks of not doing so are also clear (p6-7[91]).

The RCGP notes that mental health problems may restrict parenting capacity and advocates a comprehensive approach which encompasses developing GPs' awareness of the need to refer to health visitors for a family needs assessment[105]. The standards for post-qualifying social work in mental health suggest that mental health social workers as well as child and family social workers have a role to play in assessing parenting capacity[85].

4.4.4 Social Exclusion

The professional education guidance for social work, psychiatry, clinical psychology, health visiting, GPs and nursing and midwifery all included some recognition of the associations between parental mental health and a range of social exclusionary factors: the latter were seen to exacerbate the former. Social work's emphasis on wider environmental factors makes social exclusion a strong theme in professional education material:

> Social work intervenes at the points where people interact with their environments and has a specific contribution to make in relation to the impact on development of the family and broader environment in which children and young people grow up. Social workers need to continue to develop their knowledge and skills in relation to the impact of these factors on the development of children and young people. This includes developing knowledge and skills in relation to family functioning and the impact of wider issues such as poverty, unemployment, homelessness, racism, and those associated with domestic violence, parental mental health, drug and alcohol misuse, health, illness and disability on family life (p5[83]).

However, other professional bodies, such as the RCGP, also highlight the relationship between mental health problems, drug and alcohol misuse and social problems including domestic violence, poor housing and employment and financial problems[105].

4.4.5 Race and Ethnicity

The salience of race, ethnicity and culture in relation to mental health needs is noted in guidance on professional education from psychiatry, psychology, social work, general practice and occupational therapy[94,108,113,133]. Respecting diversity constitutes one of the *Ten Essential Capabilities* for Mental Health Practice[72] and the Ten Capabilities are cited by a number of the professional bodies in material addressing mental health work. While the Ten Essential Capabilities emphasise the importance of consultation with families, the document has little to say about patients as parents and does not address the role of children in families where parents have mental health needs.

4.5 Thinking and Acting 'Out of the Box': Towards a Family Focus in Professional Education

4.5.1 Patients as Parents

Thinking of patients as parents is identified as a skill for practitioners in medicine, psychiatry, nursing and psychology. The *New Ways of Working for Psychiatrists* report notes:

> There are many facets to people's lives; seeing them too narrowly not only risks failure to meet their needs but can also cause them and their families damage. For instance, many people, who use adult mental health services, are also parents and some of their children are at vulnerable developmental ages (p8[93]).

The BPS also highlights the dual identity of mental health service user and parent:

> Given that mental health problems are relatively common, it is inevitable that many sufferers are likely to be parents at some stage in their lives. For this reason, it is important for psychologists to consider the impact of mental heath problems upon parenting (p108[113]).

Similarly, the RCGP warns practitioners:

> Often children and young people in special circumstances are 'invisible' to the system because they live in the shadow of their parents' problems. (p12[105]).

The Chief Nursing Officer's review of the nursing contribution to the care of vulnerable children notes:

> Many adults using the NHS are parents and their children may be affected by their health. This is more likely to be the case in settings such as prisons, A&E, substance misuse services, mental health and learning disability services. Nurses need to consider the needs of a child in the family and take action if they think a child may be at risk (p30[119]).

The GSCC standards for post-qualifying social work education in mental health services go a step further in recognizing the potential for conflict between the needs of parents with mental health problems and their children:

> For social workers, this approach includes effectively managing the dilemmas that can exist between enabling and protecting people who experience mental distress. It includes identifying children in need and at risk, safeguarding their welfare and assessing parental capacity as well as addressing the mental health problems of adults and their carers, who may also be children or young people (p14[85]).

The need to prioritise the child's welfare is emphasised by the RCGP which, while advocating a family-centred approach, states clearly in its curriculum statement on the care of children and young people that 'the welfare of the child and young person must be the paramount consideration (p12[105]).

4.5.2 Interprofessional Communication

While the professional education guidance reviewed contained a considerable amount of material aimed at developing skills in interprofessional communication, few references were found to address the need for such communication in respect of parents with mental health problems and their children. However, a number of the skills in interagency communication specified by the professional bodies would clearly be of relevance to work with families where parents had mental health needs. For instance, the RCGP requires GPs to develop skills in working with professional colleagues which are broken down thus:

- Working successfully as a member of the primary care team
- Working successfully with colleagues in secondary care and elsewhere
- Working successfully with a range of other professionals such as Social Services
- In all cases, recognising that 'working successfully' involves:
- Understanding the role of professional colleagues, and where their expertise lies
- Drawing on this expertise as appropriate
- Treating colleagues with consideration and respect
- Understanding interprofessional boundaries with regard to clinical responsibility and confidentiality (p8[104]).

The RCP specifies that those qualifying in child adolescent psychiatry should:

Demonstrate practice experience and competence in consultation and liaison with the wider network of children's services such as social services, education and YOTs (p11[97]).

Guidance in nurse education provides goes further in breaking down the skill components of interprofessional communication:

In order to meet the complex needs of patients or clients, teamwork is essential. Providing care is an inter-professional and inter-agency activity, which should be based on:
* co-operation
* shared understanding
* respect.
It is important to be absolutely clear about the professional responsibilities of everyone involved and for this to be explained to the patient or client. In resolving any inter-professional differences, the patient's/client's care and needs must always be paramount.

Clause 4.2 of the Code states that:
"You are expected to work co-operatively within teams and to respect the skills, expertise and contributions of your colleagues. You must treat them fairly and without discrimination" (p1[125]).

The Chief Nursing Officer's Review of Mental Health Nursing[123] is unusual in drawing attentions to identified weaknesses in interprofessional communication. The report notes that a systematic literature search revealed that service users reported 'poor interprofessional communication, a lack of information and a lack of opportunity for collaboration in care' (p56[123]). More specific to work with families where parents have mental health needs are the GSCC's requirements for social workers undertaking postqualifying training in mental health which state that, for collaborative work, social workers must:

> • have the ability to articulate the role of the ASW in the course of contributing to effective inter-agency and inter-professional working;
> • have the ability to use networks and influence collaborative working with a range of individuals, agencies and advocates (p23[85]).

Similarly, a paper exploring specialist education for psychiatrists identifies collaboration with child protection workers as a core skill:

> Ability to recognise abuse, link with child protection agencies, plan the rehabilitation of abused children and advise on the management of failures in care giving (p37[90]).

4.5.3 Confidentiality

Professional practice in respect of confidentiality has been identified as a barrier to interprofessional work with parents with mental health problems and their children[173] and the expert consultation with users and carers for this review highlighted the importance of confidentiality (see Chapter 3). The NMC directs practitioners to consider the implications for patients of information sharing between professionals:

> It is impractical to obtain the consent of the patient or client every time it is required to share information with other health professionals or other staff involved in their care. What is important is that the patient or client understands that some information may be made available to others involved in the delivery of care. However, the patient/client must know with whom the information will be shared, and reassured that confidential information will not be disclosed outside the health care team without their consent (p1[125]).

The Chief Nursing Officer's Review notes that:

> Employers and professional leaders need to help practitioners to work through the professional dilemmas of balancing confidentiality with information sharing and clarifying different professional responsibilities within teams (p25[119]).

The Federation of Royal Colleges of Physicians also stipulates that doctors must ensure patients' confidentiality is maintained as a part of the exchange of information with other health care teams[103].

4.6 Interprofessional Learning

The government's modernisation agenda, Every Child Matters and the *Climbié Inquiry*[157] have together fuelled a range of initiatives addressing interprofessional learning in health and social care. The HE sector has produced a paper[71] which emphasised the relevance of interprofessional education for interprofessional practice and SCIE has commissioned a review on interprofessional education in social work[175]. The review found a general enthusiasm expressed for interprofessional learning: for instance, the benchmark statement for clinical psychology states that 'opportunities for interprofessional learning should be maximised' (p10[111]). However, there were few examples located of initiatives which had been implemented.

Most of the initiatives in interprofessional education identified adopted either a child protection or a mental health focus, but not both. In respect of education in mental health, the report, New Ways of Working in Mental Health, identifies a need for specialists and generalists to work together more effectively and suggests that at the postqualifying level, this can be promoted by more experienced practitioners supervising other team members and by joint learning through case discussion[78]. The RCGP's curriculum statement on mental health work proposes that GPs undertake work-based learning from colleagues in community mental health teams, graduate mental health workers and from patients and carers themselves[108].

Interprofessional learning will be a key feature of the training for the role of Approved Mental Health Professional (AMHP). This new role, outlined in the Mental Health Act 2007[46], will replace the former Approved Social Work (ASW) function. The role will be open to a range of non-medical practitioners with experience in mental health work including social workers, nurses, occupational therapists, and psychologists. The GSCC is developing specialist requirements for the role which will be endorsed by other professional bodies and the GSCC will also approve training programmes on behalf of the other regulators[143].

This trend towards inclusivity is apparent in postqualifying social work education generally with the GSCC envisaging that postqualifying modules should be available to other qualified professionals:

> The PQ framework, as a whole, is designed to promote inter-professional education. This should be reflected in the design of programmes at all levels of the framework. The great majority of modules approved for PQ should be accessible to appropriately qualified members of other professions. Other appropriately qualified individuals including users of social care services and carers should also be able to access relevant modules or units of study (p23[82]).

However, such integrated approaches are unlikely to extend to qualifying education. The CSIP and NIMHE report on the future *Social Work Contribution to Mental Health Services* noted that, at the qualifying level, mental health nursing and social work 'routes are so different that integration on the ground is going to be a practical impossibility for some years to come' (p15[73]).

In relation to interprofessional education in child protection, the RCGP's curriculum statement on the care of children advocates interprofessional case-based learning and recommends that specialist registrars should participate in interprofessional education programmes provided by child protection teams[105] The statement cites the recommendation of the Climbié Inquiry[157] that GPs should receive training in the detection of significant harm and in child protection investigations and comments on GPs' poor track record of involvement in the training functions of Area Child Protection Committees. The statement proposes that teaching teams should include a mix of professionals and envisages an increasing emphasis on interprofessional learning for GPs[105].

The Chief Nursing Officer's review of the nursing, midwifery and health visiting contribution to vulnerable children and young people[119] also identifies a need for regular multiprofessional child protection training at the postqualifying level aimed at improving integrated working. Likewise, the GSCC's *Corporate Plan* highlights the role of the Every Child Matters agenda in speeding the drive towards interprofessional education in child protection and commits itself to addressing the issues of developing training in interagency work and delivering a common core of training to multi-disciplinary teams[81]. The Corporate Plan becomes particularly relevant to the issue of parental mental health and child welfare when it notes: 'the disconnection that sometimes occurs between professionals and agencies working with children and young people, and with other vulnerable groups' (p8[81]). Also located in social work education, the Integrated Children's Services in Higher Education is an initiative[89] that aims to bring together relevant professional bodies to contribute to an evidence-based approach to developing interprofessional curricula and pedagogy for professional practice in children's services.

There is some evidence that new initiatives in children's services have stimulated interagency learning and training. The *Effective Integrated Working* report found that multi-agency training had been effective in promoting integrated working in the new Children's Trust Pathfinders. Offering places on in-house training programmes to other agencies was another approach identified and examples included awareness training on post-natal depression for children's centre staff[77].

4.7 Skills and Approaches Specific to Work with Parents with Mental Health Problems and their Children

Overall, this review found very little guidance in professional education which identified specific skills or approaches required for work with parents with mental health problems and their children. However, some examples of specialist knowledge, skills or interventions particularly relevant to work in this

field were identified. The RCP specifies that child and adolescent psychiatrists should be equipped with:

> Expert knowledge of the implications of mental and physical illness and disability, and personality disorders, for the functioning of parents (p37[90]).

The GMC report, Tomorrow's Doctors, notes the importance of medical practitioners acknowledging mental health service users' understanding and experience of their conditions and maintaining awareness of the psychological effects that this can have on them and their families[102]. The GSCC also draws practitioners' attention to service users' perspectives in this field of work emphasising the need to understand 'the experience of mental distress from the perspectives of users of social care services, their families and carers' (p13[85]).

Health visitors are encouraged to identify the mental health needs of parents in the postnatal period and to ensure access to support for both children and parents[115] and midwives are also directed to monitor and support women with mental health needs with postnatal depression or other mental illnesses[120].

However, the document reviewed which addresses parental mental health problems and child welfare most directly and fully is undoubtedly the BPS's Child Protection Portfolio[113].   The portfolio provides detailed guidance on undertaking assessments with families where parents have mental health needs and advocates that questions about familial mental health problems should be routinely incorporated into assessment and care plans. Indicators of risk to children are identified and methods of observation and information gathering are outlined[113].   Psychologists are directed to consider cultural context and diversity and to provide opportunities for children to talk about their experiences of their parents' needs. The key message is that:

> adult mental health psychologists should think family, not individual, when making assessments (p112-113[113]).

4.8   Training Materials for Work with Parents with Mental Health Problems and their Children

The key training materials targeted on work with parents with mental health needs and their children are *Crossing Bridges*[152]*,* a comprehensive resource which can be used by those training health and social care practitioners from the full range of professional groups. The pack comprises a trainer's manual and handbook and the emphasis is on fostering interprofessional communication and collaboration in work with parents with mental health needs and their children. While aimed primarily at qualified practitioners, the pack also has the potential to be used at the level of qualifying education. Audio-visual materials available for training purposes include   *Being Seen and Heard*, a training film produced by the RCP[171] which focuses on children's experiences

of parental mental health problems and identifies strategies for intervention and *Telling It Like It Is*, a video produced by a Barnardo's young carers' project in Liverpool[137]. Other training materials are identified on the Parental Mental Health and Child Welfare website, hosted by the Social Perspectives Network[178].

Case study materials focusing on families where parents have mental health needs are increasingly appearing as part of the Every Child Matters series of publications. Such case studies advocate a family centred approach[74,75], with family group conferencing identified in a case study in the 2007 White Paper on looked after children as an appropriate intervention where a parent is experiencing long term mental health problems (p33[21]). One such case study[76] considers the risks to the unborn child in relation to a mother's mental health needs. It is notable that all such case study material uses mothers' mental health problems to illustrate practice issues.

4.9   Reaching Across Roles and Specialisms

While this review has found limited evidence of professional education guidance or materials addressing parental mental health and child welfare directly or in depth, the review did identify a number of contributions to professional education and workforce debates which point to the need for services and practitioners to be more flexible and to reach across service barriers. Consultation with service users about the future role of and tasks of social work identified a need for specialisms to be revisited and rethought[140]. Social workers responding to the CSIP and NIMHE report on the social work contribution to mental health services argued that social workers' generic education should equip them to work at the interface of mental health and children's services[73]. A recent quality assurance report on social work education also noted the need for professional programmes to place more emphasis on the impact of mental health issues on children and families (p25-26[87]).

In nursing, the barriers between different branches of the profession have been identified as restrictive for both patients and practitioners:

> We also need to address the current inflexibilities and barriers in nursing that get in the way of integrated care for patients, restrict the ability to redeploy resources to shortage areas and limit career opportunities for staff. These currently exist between the branches, different parts of the register, education, research and service, and the public and independent sector (p18[124]).

While educational guidance in occupational therapy fails to mention mental health service users' roles as parents, it does note that pre-registration education for occupational therapists need to reflect the 'breadth and complexity' of mental health services (p15[133]) and the COT Standards for education advocate the involvement of service users in programme design and delivery[131].

4.10 Conclusions to the Review of Professional Education

This review found limited evidence that professional education is addressing the skills and knowledge that professionals need to work on the linked issues of parental mental health and child welfare. Whilst education guidance for most of the professional groups included here recognises the impact of parental mental health problems on children and acknowledges patients' roles as parents, little material was identified which focused in depth or detail on the skills, values or knowledge needed for this area of work. The BPS's Child Protection Portfolio[113] was an exception in this respect.

An additional review of occupational and professional requirements and standards across the seven professional groups revealed a similar picture. While skills and knowledge for interagency and interprofessional communication and work feature heavily in professional standards and competencies, skills and knowledge specific to intervention with families where parents have mental health needs were limited. This was particularly evident in the documents searched for nursing and occupational therapy. Tables 4 and 5 provide examples of these standards and requirements by professional group.

Table 4 - Professional and Occupational Standards and Requirements – Interagency and Interprofessional Skills and Knowledge

Profession	Level	Interagency/Interprofessional Skill/Knowledge
Adult psychiatry	Qualifying	Demonstrate an awareness of the roles and responsibilities of the multi-disciplinary teams within the broader health and social care context.
		Contribute to work at the interface between adult psychiatry, other subspecialties of psychiatry, other branches of medicine, and other service providers such as voluntary organisations
		Contribute to the multidisciplinary assessment of patients' needs community and hospital settings
		Describe the roles and responsibilities of other disciplines and work with them to agree an integrated care plan for management of mental illness.[96]
Child and adolescent	Qualifying	Provide a well co-ordinated multi-agency response to risk within the frameworks of the

psychiatry		Children Act, mental health law, common law, human rights and criminal justice system.
		Demonstrate an awareness of the roles and responsibilities of the multi-disciplinary teams within the broader health and social care context.
		Contribute to the multidisciplinary assessment of patients' needs in community and hospital settings
		Contribute to work at the interface between child & adolescent psychiatry, other specialties of psychiatry, other branches of medicine, and other service providers such as social services, education and voluntary organizations[97].
Clinical psychology	Qualifying	Psychologists are expected to establish orderly, clearly delineated arrangements for the joint care of clients when working with colleagues and maintain good, mutually respectful working

relationships This is especially important in multi-disciplinary team working and in inter-agency work. Psychologists need to ensure that others are kept informed of their involvement and that actions are recorded and co-ordinated with other approaches, for the benefit of the client[109].

GPs	Qualifying	All physicians need to be able to:

All physicians need to be able to:

Identify the important roles played by all members of a multi-disciplinary team

Outline the principles of effective inter-professional collaboration to optimise patient, or population, care[103].

All those graduating from undergraduate medical programmes must be able to demonstrate their ability to work effectively within a team by practising in a manner that promotes effective inter-professional activity, including shared learning[99].

Midwives	Qualifying	Acts appropriately in sharing information to enable and enhance care (Multidisciplinary team, across agency boundaries)[128]
		Work collaboratively with other practitioners and agencies (including health care and child protection) in ways which value their contribution to health and care[120].
Nursing: all nurses	Qualifying	Demonstrate knowledge of effective inter-professional working practices which respect and utilise the contributions of members of the health and social care team[127].
Health visitors	Qualifying	Work inter-professionally as a means of achieving optimum outcomes for patients/clients[126].
		Develop, sustain and evaluate collaborative work[121].
Occupational	Qualifying	Work in collaboration with other professionals to

therapists		fit in with the overall programme of intervention the service user is receiving.
		Liaise with members of the service user's care team about the discharge, closure or transfer plan, keeping them informed about how it will be implemented and followed up[134].
	Post-qualifying level	Able to develop and implement effective ways of working in networks across organisations and professional boundaries[132].
		Develops strategies for resolving ethical dilemmas in a wide range of situations including those associated with inter-agency and inter-professional working[132].
Social workers	Qualifying	Work within multi-disciplinary and multi-organisational teams, networks and systems[80].

Table 5 - Professional and Occupational Standards and Requirements – Skills and Competencies Relevant for Work with Parents with Mental Health Needs and their Children

Profession	Level	Skills and Competencies Relevant for Work with Parents with Mental Health Needs and their Children
Adult psychiatry	Qualifying	Describe to junior colleagues and other healthcare professionals mental disorders that affect adults, their presentation and impact on individuals, carers, families and society at large[96].
		Demonstrate through appropriate personal and interdisciplinary action an awareness of the risks of physical and psychological problems in the offspring of women with eating disorders[96].
		Knowledge of family life in relation to major mental illness (particularly the effects of high Expressed Emotion)[95].
Child and adolescent psychiatry	Qualifying	Knowledge of the effects of adult mental illness on children. The effect of depression and other psychiatric symptomatology on parental functioning, and the impact of this on child development and functioning. An

understanding of cultural variations in aetiology and management[94].

Undertake family interviews to take into account the different levels of power and authority of different family members at different stages of development, to engage different family members, and assess relationships between them where relevant to the mental health and functioning of the patient and family members[97].

Establish and maintain working relationships with families and carers and take their needs into management planning[97].

Clinical psychology	Core competences:
	Transferable Skills:
	- Have an understanding of the concepts of vulnerability and resilience with respect to children and families.
	- Understanding of children's problems as nested within multiple systems including the child, the family, the school and the wider social network, and knowledge of the impact of parenting practices on the psychological development of children and young people[112].
	Psychological Assessment:
	- Be aware of issues of risk and child protection when assessing children and families and be able to gather appropriate information in order to make a risk assessment, appropriate decisions regarding risk and risk management[112].

GPs	Qualifying	Adopt a family-centred approach in dealing with patients, their families and their problems. This requires: effective communication and engagement (listening to and involving children and young people, and working with parents, carers and families)[105].
		Describe the needs of children of parents with substance misuse, mental health or domestic violence problems, teenage mothers and those with severe chronic or short-term conditions that affect their capacity to parent their children; some may need referral for multi-agency assessment and support

		services: this may include referral to the health visitor for a comprehensive family needs assessment to understand and address the impact of the parent's needs on the children's health and development[105].
Midwives	Qualifying	Monitor and support women who have postnatal depression or other mental illnesses[120].
Nursing: all nurses	Qualifying	Work with the client/patient (and his/her relatives/carers), group/community/population, to consider the range of activities that are appropriate/feasible/acceptable, including the possibility of referral to other members of the health and social care team and agencies[117].
Health visitors	Qualifying	Understanding of health and altered health states through the lifespan, with particular emphasis on maternal and child health and child development, to include identification of deviation from the norm[116].

Community mental health nurses	Qualifying	Play a key role in care management and identify and select from a range of health and social care agencies those which will assist and improve the mental health care of individuals and groups[118].
Occupational therapists	Qualifying	Work collaboratively with carers[129].
Social workers	Post-qualifying (mental health)	Critical and applied understanding of the implications of mental distress for people who use services, children , families and carers[88]. AMHPs require knowledge and understanding of the particular needs of children and young people and their families and an ability to apply AMHP practice in the context of those particular needs[88].
	Post-qualifying (children and	Working with parental mental health, drug and alcohol misuse, health, illness, disability and domestic violence and the impact of these issues on children and young

young people[83,84].	
people,	
leadership	
and	
management)	
Post-qualifying (adults)	Recognition of parental responsibilities held by service users and their carers, taking into account the impact of their mental health and an awareness of the needs of dependent children and younger carers[86].

- Whilst guidance from most of the professional groups emphasised the value of interprofessional education for achieving better integrated services, progress towards realising this aspiration was limited with initiatives located at the postqualifying or specialist levels generally seeming further advanced. This pattern of development may well reflect some of the uncertainty about the value of interprofessional education at qualifying levels identified by SCIE's review of the literature on interprofessional education at the qualifying level in social work[175].

- As was found in the review of policy in this field, educational guidance and materials only very occasionally discriminated between different explanations and models of mental health need. Likewise, there was little awareness of gender in much of the material searched with few references found to fathers' mental health. The review found that diversity in respect of race and culture was more likely to be highlighted in relation to parental mental health and child welfare in the documents searched.

- Also in common with the findings from the review of policy in this field, the needs of certain groups such as young carers or new mothers assume prominence in professional education guidance. This may

reflect the successes of some campaigning organisations as well as the interests of professional groups such as midwives and health visitors.

- While the professional bodies have signalled their willingness to involve service users and carers in the design and delivery of professional programmes, the review found little evidence that they are doing this in respect of parental mental health and child welfare. The users and carers consulted warned against tokenism when involving users and carers in professional education.

- The review found increasing recognition in response to both government agendas and pressure from service users and carers that existing professional specialisms and service divides do not reflect families' needs.

- Training programmes for Approved Mental Health Professionals (AMHPs) now under development offer interprofessional learning opportunities to ensure that children's needs are acknowledged and responded to as part of the process of assessment under the Mental Health Act. There is evidence available indicating that, in the past, Approved Social Workers (ASWs) rarely engaged with children as part of their work[184].   The GSCC may have a role in ensuring that knowledge and skills concerning children's needs for explanation and discussion of parents' mental health problems and the impact on their lives are incorporated into AMHP training.

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Skills for Health (2004) HSC43 Take responsibility for the continuing professional development of self and others, Bristol: Skills for Health.

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Skills for Health (2004) HSC47 Help parents and carers to acquire and use skills to protect and take care of children and young people, Bristol: Skills for Health.

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Skills for Health (2004) HSC226 Support individuals who are distressed, Bristol: Skills for Health.

Skills for Health (2004) HSC241 Contribute to the effectiveness of teams, Bristol: Skills for Health.

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Skills for Health (2005) MCN8 Develop and agree individualised care plans for labour and birth, Bristol: Skills for Health.

Skills for Health (2005) MCN9 Develop and agree individualised postnatal care plans, Bristol: Skills for Health

Skills for Health (2005) MCN10 Implement individualised maternity care plans, Bristol: Skills for Health.

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Skills for Health (2005) MCN15 Implement interventions during labour and birth, Bristol: Skills for Health.

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Skills for Health (2005) MH11 Enable families to address issues with individuals' behaviour, Bristol: Skills for Health.

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Skills for Health (2005) MH24 Implement, monitor and evaluate therapeutic interventions within an overall care programme, Bristol: Skills for Health.

Skills for Health (2005) MH25 Contribute to the assessment of needs and the planning, evaluation and review of individualised programmes of care for individuals, Bristol: Skills for Health.

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Skills for Health (2007) CS7 Co-ordinate the delivery of care plans to meet the health and well-being needs of children and young people, Bristol: Skills for Health.

Skills for Health (2007) CS17 Ensure systems and procedures for safeguarding children and young people are implemented, Bristol: Skills for Health.

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APPENDIX 2 - Search Terms Used for the Reviews

Search Terms used for Policy Review

Children's Social Care
parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
parents' mental ill-health
parents' mental ill health
mothers' mental ill-health
mother's mental ill health
fathers' mental ill-health
fathers' mental ill health
carers' mental ill-health
carers' mental ill health
maternal mental ill-health
maternal mental ill health
family mental ill-health.
family mental ill health
parental psychiatric illness
parents' psychiatric illness
mothers' psychiatric illness
fathers' psychiatric illness
carers' psychiatric illness
maternal psychiatric illness
family psychiatric illness.
parental psychiatric disorder
parents' psychiatric disorder
mothers' psychiatric disorder
fathers' psychiatric disorder
carers' psychiatric disorder
maternal psychiatric disorder
family psychiatric disorder.
depression
post-natal depression

postnatal depression
post natal depression
peri-natal depression
perinatal depression
peri natal depression
ante-natal depression.
antenatal depression
ante natal depression
parental capacity
assessment of parents
parenting problems
parenting difficulties.
young carers
adults' and children's services collaboration
adults' and children's services co-ordination
adults' and children's services coordination
adults' and children's services co ordination
children and adult services
mental health social work
mental health services and children's services
psychiatric services
inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary

Mental Health
post-natal depression
postnatal depression
post natal depression
peri-natal depression
perinatal depression
peri natal depression
ante-natal depression.
antenatal depression
ante natal depression
parental capacity
assessment of parents
parenting problems
parenting difficulties.
young carers
adults' and children's services collaboration
adults' and children's services co-ordination

adults' and children's services coordination
adults' and children's services co ordination
children and adult services
child care social work
mental health services and children's services
inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary
child well-being
child well being
child wellbeing
child welfare
safeguarding children
protecting children
child protection

Health
parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
parents' mental ill-health
parents' mental ill health
mothers' mental ill-health
mother's mental ill health
fathers' mental ill-health
fathers' mental ill health
carers' mental ill-health
carers' mental ill health
maternal mental ill-health

maternal mental ill health
family mental ill-health.
family mental ill health
parental psychiatric illness
parents' psychiatric illness
mothers' psychiatric illness
fathers' psychiatric illness
carers' psychiatric illness
maternal psychiatric illness
family psychiatric illness.
parental psychiatric disorder
parents' psychiatric disorder
mothers' psychiatric disorder
fathers' psychiatric disorder
carers' psychiatric disorder
maternal psychiatric disorder
family psychiatric disorder.
post-natal depression
postnatal depression
post natal depression
peri-natal depression
perinatal depression
peri natal depression
ante-natal depression.
antenatal depression
ante natal depression
parental capacity
assessment of parents
parenting problems
parenting difficulties.
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adults' and children's services collaboration
adults' and children's services co-ordination
adults' and children's services coordination
adults' and children's services co ordination
children and adult services
child care social work
mental health social work
mental health services and children's services
psychiatric services
inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary

inter disciplinary
child well-being
child well being
child wellbeing
child welfare
safeguarding children
protecting children
child protection

Adult Social Care and Criminal Justice

parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
parents' mental ill-health
parents' mental ill health
mothers' mental ill-health
mother's mental ill health
fathers' mental ill-health
fathers' mental ill health
carers' mental ill-health
carers' mental ill health
maternal mental ill-health
maternal mental ill health
family mental ill-health.
family mental ill health
parental psychiatric illness
parents' psychiatric illness
mothers' psychiatric illness
fathers' psychiatric illness
carers' psychiatric illness
maternal psychiatric illness
family psychiatric illness.
parental psychiatric disorder
parents' psychiatric disorder
mothers' psychiatric disorder
fathers' psychiatric disorder
carers' psychiatric disorder

maternal psychiatric disorder
family psychiatric disorder.
depression
post-natal depression
postnatal depression
post natal depression
peri-natal depression
perinatal depression
peri natal depression
ante-natal depression.
antenatal depression
ante natal depression
parental capacity
assessment of parents
parenting problems
parenting difficulties.
young carers
adults' and children's services collaboration
adults' and children's services co-ordination
adults' and children's services coordination
adults' and children's services co ordination
children and adult services
child care social work
mental health social work
mental health services and children's services
psychiatric services
inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary
child well-being
child well being
child wellbeing
child welfare
safeguarding children
protecting children
child protection

Search Terms used for Professional Education Review

Social Work
parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
parents' mental ill-health
parents' mental ill health
mothers' mental ill-health
mother's mental ill health
fathers' mental ill-health
fathers' mental ill health
carers' mental ill-health
carers' mental ill health
maternal mental ill-health
maternal mental ill health
family mental ill-health.
family mental ill health
parental psychiatric illness
parents' psychiatric illness
mothers' psychiatric illness
fathers' psychiatric illness
carers' psychiatric illness
maternal psychiatric illness
family psychiatric illness.
parental psychiatric disorder
parents' psychiatric disorder
mothers' psychiatric disorder
fathers' psychiatric disorder
carers' psychiatric disorder
maternal psychiatric disorder
family psychiatric disorder.
depression
post-natal depression
postnatal depression
post natal depression
peri-natal depression

perinatal depression
peri natal depression
ante-natal depression.
antenatal depression
ante natal depression
parental capacity
assessment of parents
parenting problems
parenting difficulties
young carers
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adults' and children's services coordination
adults' and children's services co ordination
children and adult services
child care social work
mental health social work
mental health services and children's services
psychiatric services
inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary

Psychiatrists
parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
parents' mental ill-health
parents' mental ill health

mothers' mental ill-health
mother's mental ill health
fathers' mental ill-health
fathers' mental ill health
carers' mental ill-health
carers' mental ill health
maternal mental ill-health
maternal mental ill health
family mental ill-health.
family mental ill health
parental psychiatric illness
parents' psychiatric illness
mothers' psychiatric illness
fathers' psychiatric illness
carers' psychiatric illness
maternal psychiatric illness
family psychiatric illness.
parental psychiatric disorder
parents' psychiatric disorder
mothers' psychiatric disorder
fathers' psychiatric disorder
carers' psychiatric disorder
maternal psychiatric disorder
family psychiatric disorder.
depression
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postnatal depression
post natal depression
peri-natal depression
perinatal depression
peri natal depression
ante-natal depression.
antenatal depression
ante natal depression
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child care social work
mental health social work
mental health services and children's services
inter-professional collaboration
interprofessional collaboration
inter professional collaboration

inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary
child well-being
child well being
child wellbeing
child welfare
safeguarding children
protecting children
child protection

GPs, Health Visitors, Midwives, Nursing (all), Psychologists, Occupational Therapists

parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
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mothers' mental ill-health
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carers' mental ill health
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inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
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inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary
child well-being
child well being
child wellbeing
child welfare
safeguarding children

protecting children
child protection

Interprofessional Education Documents

parental mental health
parents' mental health
mothers' mental health
fathers' mental health
carers' mental health
maternal mental health
family mental health.
parental mental disorder
parents' mental disorder
mothers' mental disorder
fathers' mental disorder
carers' mental disorder
maternal mental disorder
family mental disorder.
parental mental ill-health
parental mental ill health
parents' mental ill-health
parents' mental ill health
mothers' mental ill-health
mother's mental ill health
fathers' mental ill-health
fathers' mental ill health
carers' mental ill-health
carers' mental ill health
maternal mental ill-health
maternal mental ill health
family mental ill-health.
family mental ill health
parental psychiatric illness
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mothers' psychiatric illness
fathers' psychiatric illness
carers' psychiatric illness
maternal psychiatric illness
family psychiatric illness.
parental psychiatric disorder
parents' psychiatric disorder
mothers' psychiatric disorder
fathers' psychiatric disorder
carers' psychiatric disorder
maternal psychiatric disorder
family psychiatric disorder.
depression
post-natal depression
postnatal depression
post natal depression

peri-natal depression
perinatal depression
peri natal depression
ante-natal depression.
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inter-professional collaboration
interprofessional collaboration
inter professional collaboration
inter-agency
interagency
inter agency
multi-professional
multi professional
inter-disciplinary
interdisciplinary
inter disciplinary
child well-being
child well being
child wellbeing
child welfare
safeguarding children
protecting children
child protection

Appendix 3 - Frameworks Used for Analysis

Policy Review - Framework for Analysis

A. UNDERSTANDING THE ISSUE/LINKS

A1 Adverse effects of parental mental health needs on children

    A1.1 Outcomes for children including:

    A1.1a Delay in development;

    A1.1b Child mental health problems;

    A1.1c Anti-social and offending behaviours;

    A1.1d Boys' (lack of) achievement;

    A1.1e Looked-after children.

A2 Abuse and Neglect

A3 Parenting capacity including:

    A3.1 Problems and breakdowns

    A3.2 Parental history of abuse

A4 High risk

    A4.1 High risk – fabricated illness

A5 Association with Social Exclusion

    A5.1 Poverty /low income

    A5.2 Drug use

    A5.3 Young parents

    A5.4 Limited access to services

    A5.5 Poor housing conditions

    A5.6 Lone parents

    A5.7 Learning disabilities

    A5.8 Domestic Violence

A5.9 Ethnicity

A5.10 Stigma/ image of mental illness

A6 Resilience

A7 Fathers

A8 Motherhood/caring responsibilities contributing to mental health problems

B MOVING TOWARDS A FAMILY FOCUS: RECOGNISING MULTIPLE NEEDS AND COMMUNICATING AND WORKING ACROSS SERVICE DIVIDES

B1 Responsibilities/ duty to take account of children's needs (C ACT 2004)

B1.1 Prioritising needs of child

B2 Identifying Young Carers

B3 Staff Awareness including:

B3.1 Adult MH services – awareness of children's needs and parents' status as parents

B3.2 Routine recording of parent status;

B3.3 CPA

B3.4 FACS

B3.5 Interagency Communication

B 3.6 Integrated recording systems

B3.7 Information exchange

B3.8 Confidentiality

B3.10 Communication re high risk

B3.11 Awareness of other professionals' roles

B4 Interagency co-ordination/collaboration

C. DELIVERING SERVICES

Professional Education Review - Framework for Analysis

A. UNDERSTANDING THE ISSUE/LINKS

A1 Impact of parental mental health needs on children

A2 Parents and gender

A3 Parenting capacity

A4 Association with Social Exclusion

    A5.1 Poverty /low income

    A5.2 Drug use

    A5.3 Young parents

A5.4 Limited access to services

A5.5 Poor housing conditions

A5.6 Lone parents

A5.7 Learning disabilities

A5.8 Domestic Violence

A5.9 Ethnicity

A5.10 Stigma/ image of mental illness

A5 Resilience

A6 Fathers

A7 Motherhood/caring responsibilities contributing to mental health problems

B. RECOGNITION OF MULTIPLE ROLES/DUTIES – THINKING, AND ACTING OUT OF THE BOX

B1 Patients as parents

B2 Interprofessional Communication

B3 Confidentiality

C. INTERPROFESSIONAL LEARNING

C1 Qualifying education

C2 Postqualifying education

D. SKILLS AND APPROACHES SPECIFIC TO WORK WITH PARENTS WITH MENTAL HEALTH PROBLEMS AND THEIR CHILDREN

E. TRAINING MATERIALS FOR WORK WITH PARENTS WITH MENTAL HEALTH PROBLEMS AND THEIR CHILDREN

F. BREAKING DOWN SERVICE DIVIDES AND SPECIALISMS

Appendix 4 - Websites Searched

Review of Policy

- Audit Commission (www.audit-commission.gov.uk)
- Care Services Improvement Partnership (www.csip.org.uk)
- Department for Education and Skills (now Department for Children, Families and Schools) (www.dfes.gov.uk)
- Department of Health (www.dh.gov.uk)
- Every Child Matters (www.everychildmatters.gov.uk)
- National Institute for Mental Health in England (www.nimhe.csip.org.uk)
- Royal College of Psychiatrists (www.rcpsych.ac.uk)
- SCIE (www.scie.org.uk)
- Social Exclusion Unit (http://archive.cabinetoffice.gov.uk/seu/)
- The Cabinet Office (www.cabinetoffice.gov.uk)
- The Home Office (now Ministry of Justice) (www.homeoffice.gov.uk)

Review of Professional Education

- British Psychological Society (BPS) (www.bps.org.uk)
- Children's Workforce Development Council (www.cwdcouncil.org.uk)
- College of Occupational Therapists (www.cot.org.uk)
- Committee of General Practice Education Directors (COGPED) (www.cogped.org.uk)
- Department for Education and Skills (now Department for Children, Schools and
- Families) (www.dfes.gov.uk)
- Department of Health (www.dh.gov.uk)
- East Midlands Healthcare Workforce Deanery (www.eastmidlandsdeanery.nhs.uk)
- General Social Care Council (GSCC) (www.gscc.org.uk)
- General Medical Council (GMC) (www.gmc-uk.org)
- Health Professions Council (www.hpc-uk.org)
- Higher Education Academy (www.heacademy.ac.uk)
- Higher Education Funding Council for England (HEFCE) (www.hefce.ac.uk)
- London Deanery (www.londondeanery.ac.uk)
- National Association of Pastoral Care in Education (NAPCE) (www.napce.org.uk)
- North Western Deanery (www.nwpgmd.nhs.uk)
- Nursing and Midwifery Council (www.nmc-uk.org)
- Postgraduate Medical Curriculum for General Practice (www.gpcurriculum.co.uk)
- Postgraduate Medical Education Training Board (www.pmetb.org.uk)
- Quality Assurance Agency (QAA) (www.qaa.ac.uk)
- Royal College of General Practitioners (www.rcgp.org.uk)
- Royal Colleges of Physicians (www.rcplondon.ac.uk)
- Royal College of Psychiatrists (www.rcpsych.ac.uk)

- Royal College of Nursing (www.rcn.org.uk)
- SCIE (www.scie.org.uk)
- Skills for Care (www.skillsforcare.org.uk)
- Skills for Health (www.skillsforhealth.org.uk)
- UK Conference of Postgraduate Education Advisors in General Practice (UKCEA) (www.napce-online.org.uk)