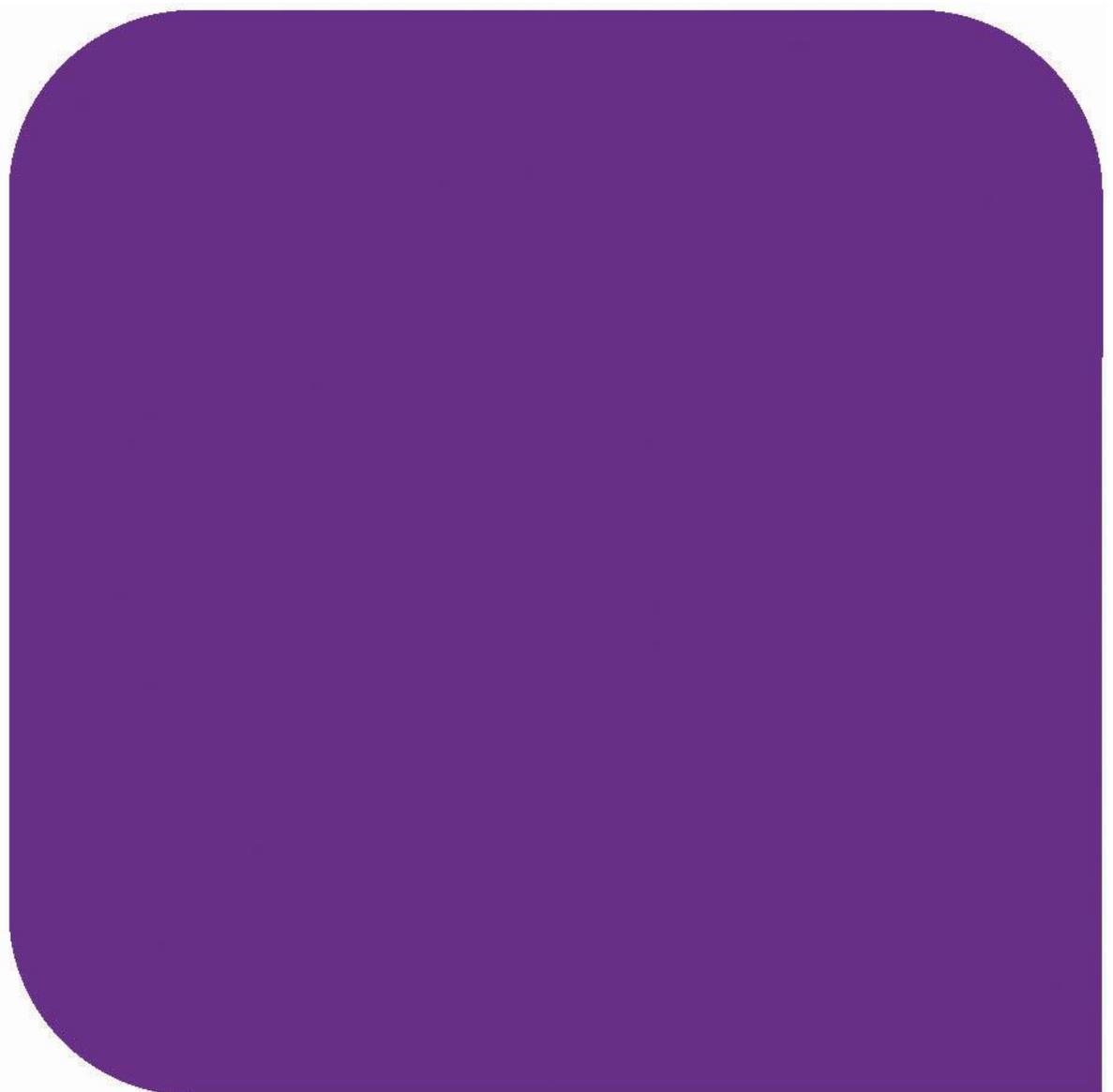




social care
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**FAMILIES AND CHILDREN'S
SERVICES: REPORT 56**

Think child, think parent, think family: final evaluation report



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Think child, think parent, think family: final evaluation report

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Executive summary

Background

The mental health and wellbeing of children and adults in families where a parent has a mental health problem are closely linked. Not all families need health and social care services. However, those that do often struggle to get accessible and effective support that addresses children's needs and recognises the parental responsibilities of many adults with mental health problems.

In July 2009, the Social Care Institute for Excellence (SCIE) published a guide entitled *Think child, think parent, think family: a guide to parental mental health and child welfare* to help services improve their response to parents with mental health problems and their families. This document and its overall ethos are here referred to as 'think family'. This is the final evaluation report of the project, documenting the progress made by the sites involved, and making recommendations for future activity.

Implementation and evaluation

Between September 2009 and September 2011, SCIE worked with five local authority areas (sites) in England and the five health and social care trust areas (sites) in Northern Ireland to implement the recommendations in the guide. The Northern Ireland project concluded in March 2012.

SCIE has evaluated this work to capture learning about how to implement the guide. The evaluation investigated the following key questions:

- What processes and practices are effective in implementing the *Think child, think parent, think family* guide?
- What are the barriers and enablers for implementing the guide?

Learning about practice

Overview

Looking across all the sites, good progress has been made against many of the recommendations in the guide. Sites have offered useful insights into how to implement the recommendations, in particular within the resource constraints which are now prevalent across services and sites.

Between sites, there has been variation in the extent of progress, reflecting to some extent the different starting points of the different sites. In Northern Ireland the project was led and managed at a regional as well as a local level. This helped the Northern

Ireland sites to make more comprehensive and far reaching changes, and develop partnerships with key strategic partners in government, higher education and regulation.

Activities to implement the recommendations

Sites have undertaken a range of activities across the care pathway to implement the recommendations:

- **strategic approach** – developing and updating think family strategies; developing a communication strategy; embedding a think family approach in service restructuring
- **involving families** – through representation on the project and creation of user consultation groups
- **workforce development** – development of a ‘practitioner champions’ group, awareness-raising and both multi- and single-agency training
- **improving access to services** – reviewing screening tools to ensure they are fit for purpose; developing arrangements to cross-reference electronic databases when certain thresholds are met (e.g. checking the adult mental health database when a child protection investigation is instigated)
- **assessment** – amending assessment tools in children’s services to ensure that they refer to parental mental ill health; clarifying thresholds for assessment in children’s services through documentation and training, including adult workers; and using common assessment framework (CAF)/*Understanding the needs of children in Northern Ireland* (UNOCINI) (WELB 2008) processes to support families affected by parental mental ill health
- **planning and reviewing care** – development of protocols to facilitate joint working between adults’ and children’s services; use of the CAF to facilitate integrated care planning and review.

New areas of practice

In addition to making progress on the recommendations in the guide, sites also developed new approaches, including:

- the development of a knowledge and skills framework
- the use of a family experience survey to engage with service users and measure progress over time
- the development of a set of standardised screening questions for use across a range of statutory and voluntary organisations
- embedding think family within existing training opportunities
- exploring the use of the CAF and pre-CAF as a means of identifying and addressing the needs of the whole family

- the creation of posts embedded within other teams – for example, embedding family support workers in community mental health teams (CMHTs).

Learning about the process

In the English sites and, to a lesser extent the Northern Ireland sites, the process of implementation has been more 'organic' than expected. This manifests itself in two main ways. Firstly, rather than sites implementing and rolling out a specific number of new, rigidly pre-planned activities, they have instead started to embed a think family approach in multiple existing documents and ways of working. This approach is sometimes termed 'riddling the system' (Evans 1996).

The approach taken by the sites has also been organic in that they have responded to opportunities and changes in the practice and policy environment. For example, one site incorporated a think family approach into a new structure for children's services.

The experience of the sites has shown that not all activities need to be large-scale or costly to have a positive impact. A number of sites have undertaken relatively quick and low-cost actions, which have helped to start the process of change.

Barriers and enablers

Significant determinants in helping or hindering progress were:

- **competing pressures** – improving services was challenging because of people's overflowing schedules and conflicting demands
- **senior support** – the active backing of senior staff was probably the most important factor determining whether sites made concrete changes to working practices
- **organisational and professional attitudes to change** – people's willingness to view their remit flexibly made a real difference to what could be achieved
- **time to build relationships** – in sites with a history of multi-agency working, key relationships were already in place. Elsewhere, some steering group and project team members were meeting for the first time, so early encounters were spent learning about each other's roles, and building relationships and trust
- **resources** – many difficulties, such as a lack of knowledge and understanding of other roles, cannot necessarily be solved by more money. However, the broader financial climate did have a negative impact on sites' capacity to implement a think family approach. Specific grants were cut and redundancies meant that those remaining in post had even greater workloads
- **administrative and project management support** – to co-ordinate work and ensure tasks were completed.

Recommendations for future work

There were some key barriers that the sites continued to encounter which would benefit from further investigation.

The inability to cross-reference electronic databases used in children's social care services and adult mental health services remained a barrier across all the sites. This issue appears to be very difficult to tackle on a local level and may benefit from investigation at a national level.

Linked to the above, there are still barriers to developing meaningful indicators that would help to measure progress in improving outcomes for families affected by parental mental ill health. The increasing emphasis on localism may mean that local sites and regions have more flexibility to work on this in the future than previously.

This project included some promising exploration of the potential for the CAF in children's services to be used to support integrated working. There was less exploration of the possibilities offered by the care programme approach (CPA) used in mental health services, which we feel would merit further investigation.

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

1 Introduction

Between September 2009 and September 2011 SCIE worked with five English local authority areas (sites), and the five Northern Ireland health and social care trust areas (sites) to implement the recommendations of *Think child, think parent, think family: a guide to parental mental health and child welfare* (SCIE 2009). This is the final evaluation report of the project, documenting the progress made by the sites involved, and making recommendations for future activity, building on the interim evaluation report of the first year of the project (SCIE 2011).

The report begins by outlining the methodology used for the evaluation. It then documents the learning from the sites, considering first what changes to practice have been made and how this has been achieved and, secondly, the process of change and what has helped and hindered this. Finally, we suggest some recommendations for future work in this area.

1.1 Terminology

The terms 'Think child, think parent, think family' and the shorthand 'think family' denote a whole-family approach to service delivery, in this case in relation to mental health services. It is important to note that this work is related to, but distinct from, the former cross-governmental think family initiative.

Throughout the report we discuss local organisations and agencies. In all sites, these include local voluntary as well as statutory services. We have used the term local authority or health and social care trust *areas* to denote all services operating within those areas, but not restricted to local authority or trust-operated services.

2 Background

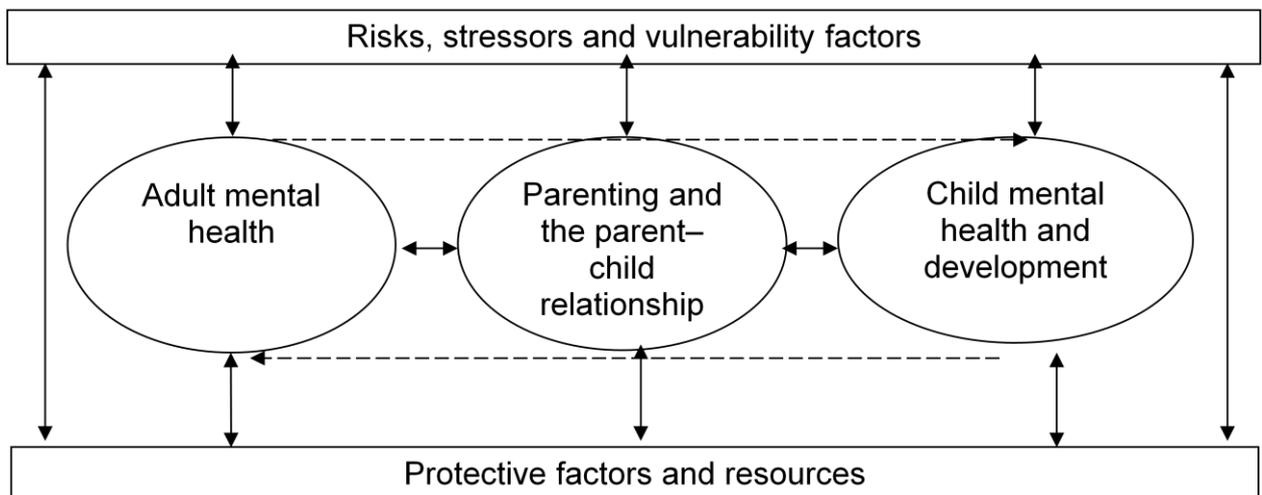
2.1 Links between parental mental health and child welfare

Families with a parent with mental health problems often have complex needs. Not all families affected by parental mental ill health need the support of health and social care services, but those that do can find it difficult to get effective support for the *whole* family.

SCIE's approach to parental mental health and child welfare has its basis in the family model (Falkov, 1998). This model (see Figure 1) suggests that the mental health and wellbeing of the children and adults in a family where a parent has a mental health problem are linked in at least three ways:

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

Figure 1 The family model (Falkov 1998)



2.1.1 A lack of joined-up working

Despite the importance of the interaction between the mental health of the parent and the safety and welfare of the child, services tend to be structured around either the adult with the mental health problem, *or* the needs of children (Stanley & Cox, 2009).

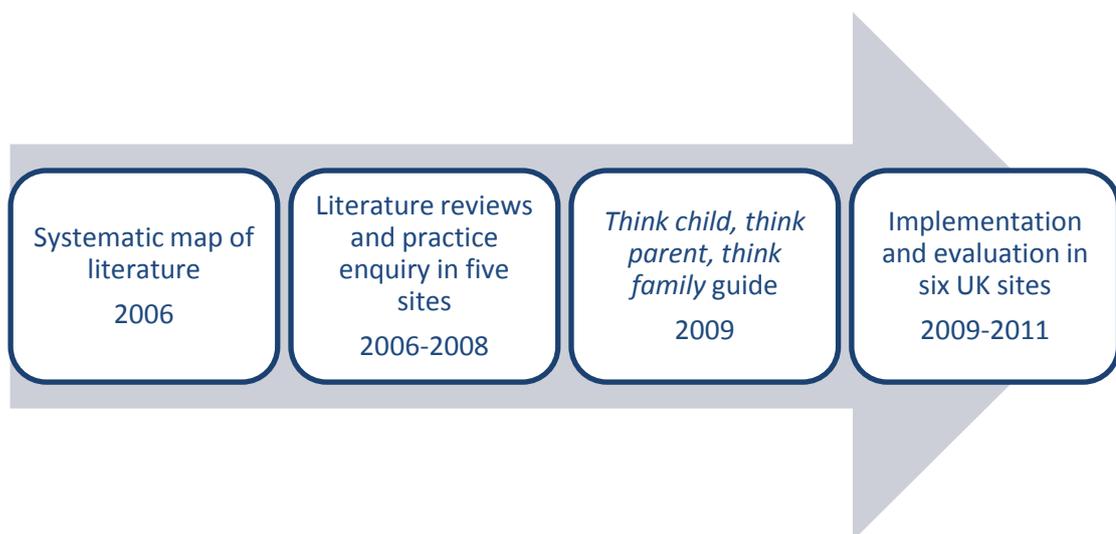
Adults' and children's services are frequently separated by the organisation within which they are located (e.g. National Health Service – versus local authority), professional

background of staff, policy and legislative imperatives, information and recording systems and organisational cultures. Practitioners may also be reluctant to work outside what they see as their professional boundaries (SCIE, 2009).

2.2 Project background

As shown in Figure 2, SCIE has undertaken several phases of work looking at how services can better support parents with mental health problems and their families.

Figure 2 SCIE's work on parental mental health and child welfare



2.2.1 Systematic map and literature reviews

The project began by reviewing the existing evidence in this area. A systematic map of the literature was compiled by SCIE's scoping and searching team, followed by reviews of the literature on:

- incidence, detection, acceptability and effectiveness (Parker *et al.*, 2009)
- professional education and policy (Stanley and Cox, 2009).

A practice enquiry was also conducted in five sites in England, looking at current practice in relation to parents with mental health problems.

2.2.2 The Think child, think parent, think family guide

SCIE then produced a guide to improving services (2009), which recommends a think family approach across adult mental health and children's services. The guide makes specific recommendations relating to screening, assessment, planning, providing and reviewing care, actions at the strategic level and workforce development. It makes recommendations about what practitioners, managers and organisations can do. The eight priority recommendations in the guide are shown in Box 1.

Box 1 *Think child, think parent, think family* guide priority recommendations

1 Signposting and improving access to services

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

2 Screening

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

3 Assessment

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

4 Planning care

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

5 Providing care

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

6 Reviewing care plans

Reviews should consider changes in family circumstances over time and include both individual and family goals. Children and carers should be involved in the process.

7 Strategic approach

Multi-agency, senior-level commitment is required and we recommend that a think family strategy is developed to implement this guidance and that parents, children and carers are involved in all stages.

8 Workforce development

Investment is needed in training and staff development for adult and children’s front-line managers and practitioners to support the changes recommended in the guide in relation to how to think family and work across service interfaces.

2.2.3 Implementation and evaluation

The final phase of the project, on which this report focuses, has been work to implement the guide with a range of statutory and non-statutory agencies working in the five sites who took part in the practice survey, plus the five health and social care trust areas in Northern Ireland. The aims of this phase are detailed below.

2.3 Project aims and setup

The aim of the implementation phase was to generate learning about how to put the guide into practice. We aimed to work with services in a range of local areas who would act as 'pathfinders', trying out ways of implementing the guidance which could then be evaluated and disseminated to other sites.

2.3.1 Recruitment of sites

We invited the five sites who had taken part in the practice survey to be implementation sites. All agreed to take part. The sites were:

- Birmingham
- Lewisham
- Liverpool
- North Somerset
- Southwark.

We were also approached by the Department of Health, Social Services and Personal Safety (DHSSPS) in Northern Ireland. Services in the region were starting a programme of work to improve joint working between children's services and adult mental health services partly prompted by the report of the inquiry into the deaths of Madeleine and Lauren O'Neill (Western and Eastern Health and Social Services Boards 2007). It was agreed that the five health and social care trust areas would also be implementation sites for the project.

2.3.2 Timescales

The first meeting of the SCIE team and representatives from all the sites took place in September 2009. The implementation work supported by SCIE continued in the English sites until September 2011, and in the Northern Irish sites until March 2012. However, the sites were committed to continuing to implement a think family approach after the SCIE-supported project had ended.

2.3.3 Funding

There was a small amount of funding available for the project. The English sites each received £10,000 from the Department of Health (DH) to assist with implementation. The work in Northern Ireland was supported by two project managers, located within the

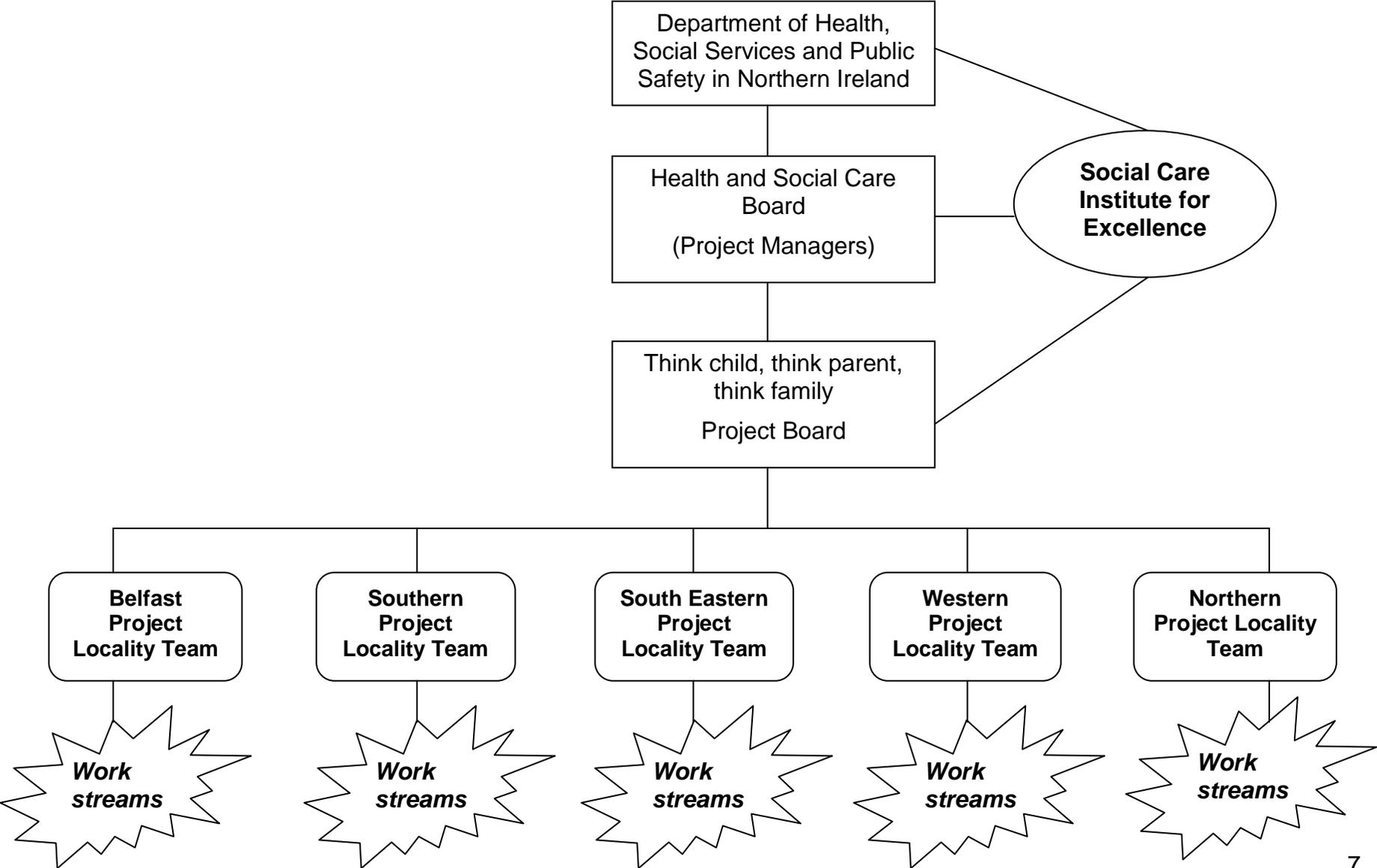
health and social care board (HSCB) and funded by DHSSPS, but did not have a budget additional to this.

2.3.4 Who was involved?

In England, we worked with a multi-agency project steering group in each site, which was responsible for planning and co-ordinating the implementation of SCIE's *Think child, think parent, think family* guide.

In Northern Ireland, the project was led by two project managers funded by the DHSSPS. They were supported by the HSCB and by a regional-level project board comprising approximately 25 members from across relevant services. Local implementation was carried out by project locality teams in each of the five trust areas (see Figure 3).

Figure 3. Northern Ireland project structure (reproduced with their permission)



2.3.5 SCIE support

Each of the English sites was offered support from a SCIE practice development manager to contribute to their steering group meetings and provide help in between meetings. In Northern Ireland, support was offered at a regional level to the two project managers from a SCIE practice development manager based there. The practice development managers provided a range of support, including reviewing documentation, convening meetings and sharing learning from other sites.

SCIE also organised quarterly meetings for all the sites to share experiences and learning. These were held at each of the sites in turn, with the exception of Northern Ireland due to the high travel costs for the other five sites.

SCIE provided an online forum for sites to share information and post messages. However, take-up of this was low, with information sent out and shared largely by email.

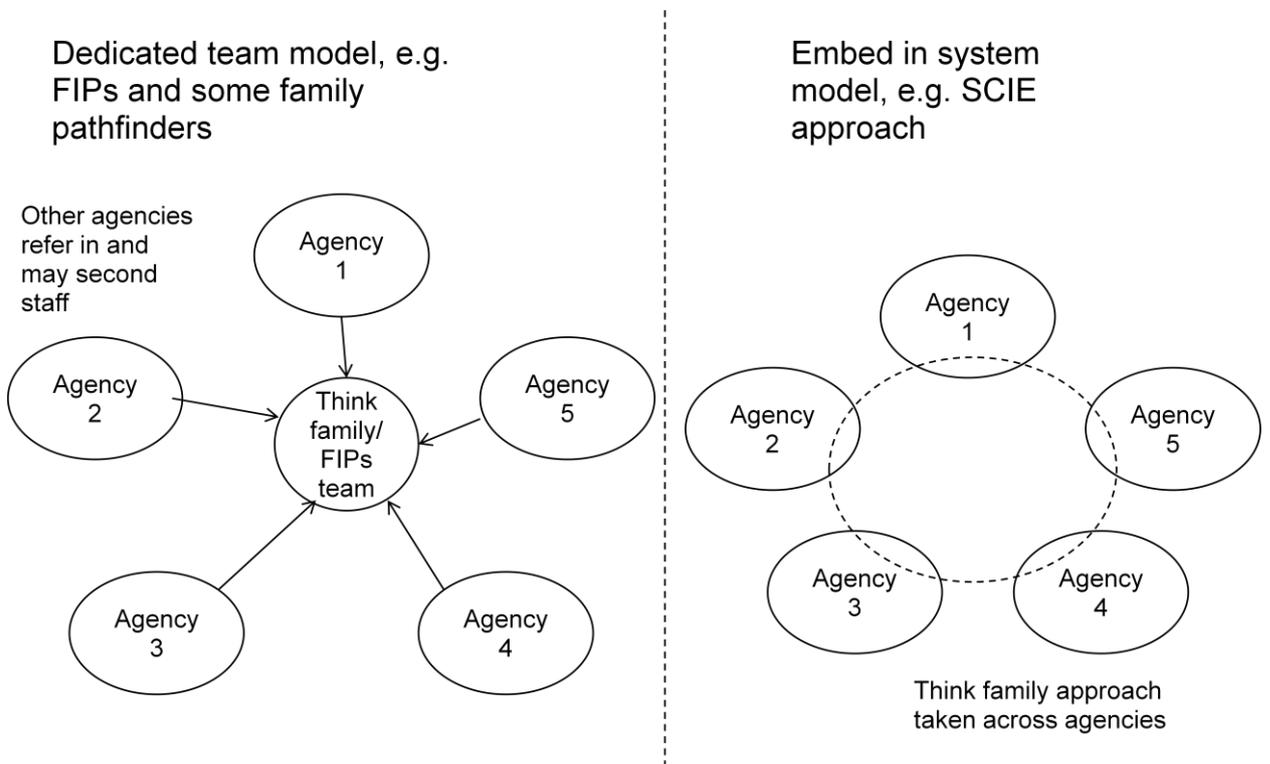
2.4 Related projects

This project was set up shortly after the English government made funding available to establish family intervention projects (FIPs) and 16 family pathfinders. SCIE's work with the sites had some similarities to these projects – principally, a focus on working with the whole family. However, it is worth briefly noting some of the differences between the SCIE project and these two initiatives. In the FIPs and family pathfinders, there was an emphasis on developing new multi-agency teams who would work intensively with families with multiple problems, and significant funding was provided to support this.

Families would be referred to these teams by existing services, meaning that the projects had a clearly identifiable set of service users.

In contrast, SCIE's model was to work with existing statutory and non-statutory services to encourage them to think family and better join up what they do. These different models are illustrated in Figure 4.

Figure 4 Different Think family approaches



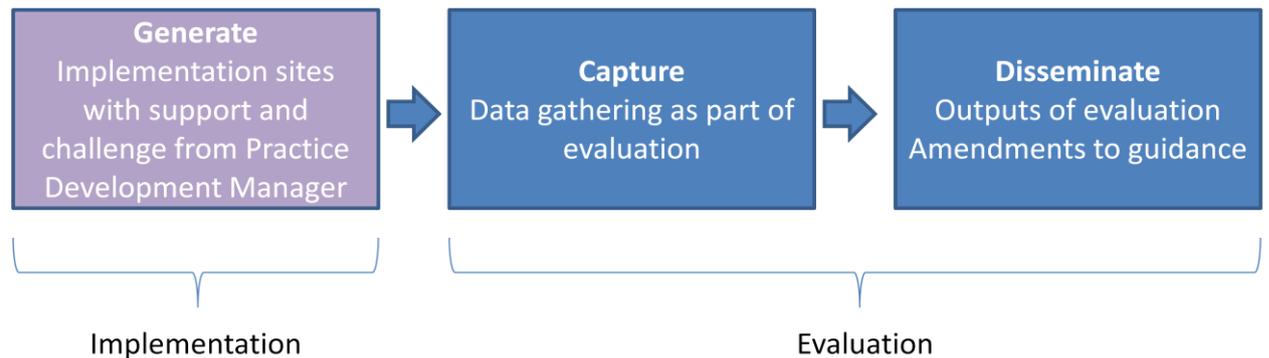
It is interesting to note that, during the SCIE project, the main the funding period for most FIPs and family pathfinders came to an end, meaning that some areas were considering the more embedded model that our sites have employed from the outset. The SCIE implementation sites may therefore be able to provide some useful learning for other areas looking to embed a think family approach within existing teams and structures.

3 Evaluation methodology

3.1 Aims

The principal aim of the evaluation was to capture and report the learning from the implementation sites, as illustrated in Figure 5.

Figure 5 Model for learning from implementation sites



The evaluation therefore investigated the following key questions:

1. What **processes and practices** are effective in implementing the guide?
2. What are the **barriers and enablers** for implementing the guide?

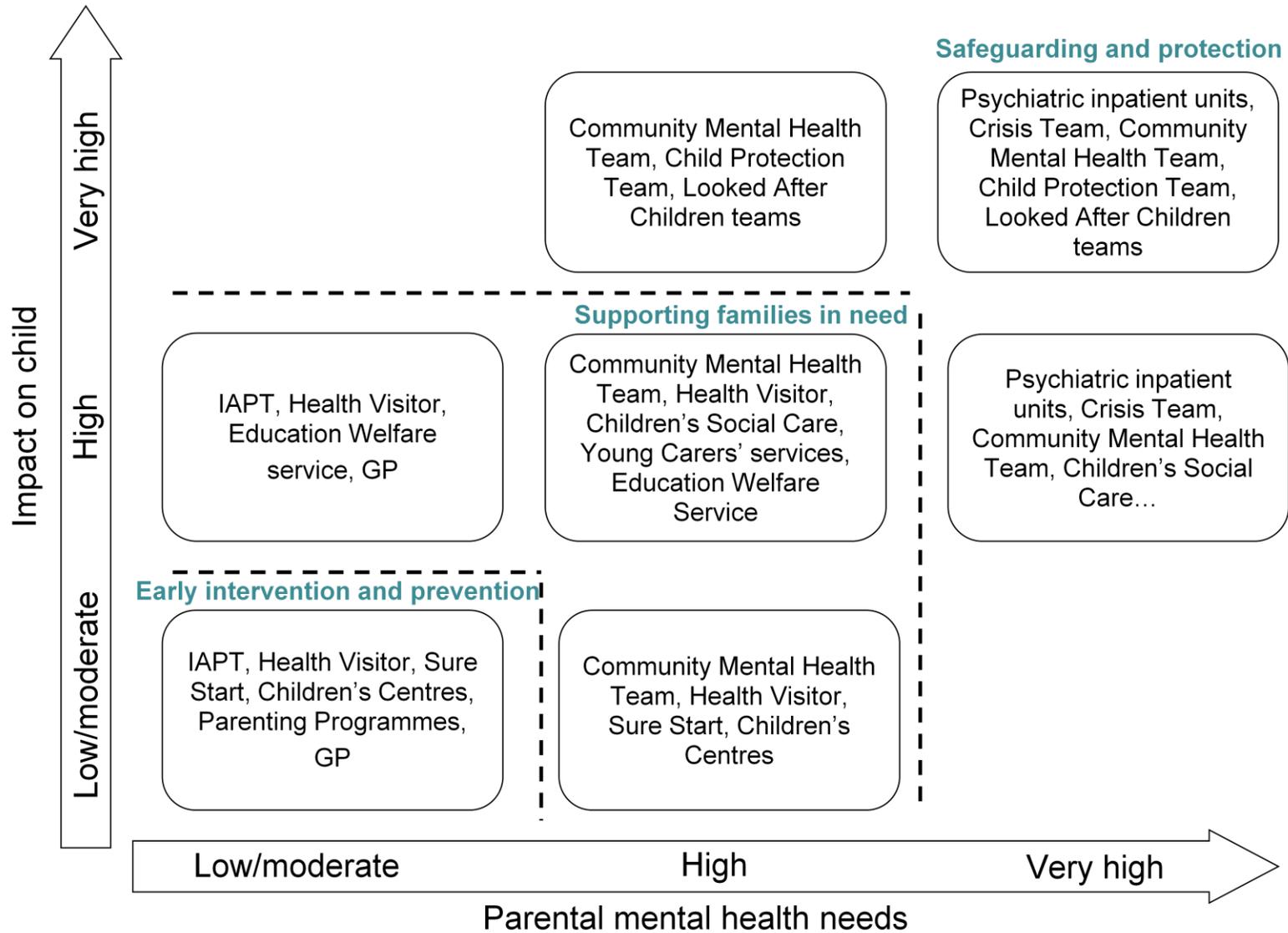
We had also hoped to investigate the impact on staff and service users of implementing the guidance. However, we were not able to do so, as detailed in Section 3.3.

3.2 Methodology

Early analysis (Roscoe 2010) identified that implementation of the guide bore many of the hallmarks of a 'complex intervention' (MRC, 2000, 2008) in three key ways.

- **Opportunity for local flexibility and tailoring**
Early indications from SCIE's work with the implementation sites suggested that there would be significant tailoring of the guide to suit local circumstances – for example, implementing only parts of the guide or adopting slightly different mechanisms for implementation.
- **Targeting multiple parts of the 'system'**
The guide makes recommendations for 'Staff in mental health and children's services from all sectors' (SCIE, 2009, p.1). Particular teams or staff groups are intentionally not specified within the guide: it was SCIE's intention that the guide be widely applicable across the sector, and the specific inclusion of some teams or staff groups could be taken to imply exclusion of other groups. However, neither mental health nor children's services are monolithic, but comprise a set of services designed to meet differing levels and types of need. The implementation of the guide could therefore potentially entail targeting a number of different agencies and groups within the health and social care system, as shown in Figure 6.
- **A range of potential outcomes**
The think family approach can be applied to a number of different services within children's services and AMHS. This means that what constitutes a good outcome will vary in different settings.

Figure 6 Different levels of need



In order to take account of this complexity, the evaluation has employed a qualitative approach, drawing on the principles of realist (Pawson and Tilley, 1997) and naturalistic (Patton 1998) evaluation. Key to these approaches are:

- **describing** the process and practice of implementation, as experienced by those in the sites – not just what the evaluator *expected* it to be
- **prioritising** data from those involved in the programme, who should be seen as key informants whose understanding of the data is *ahead of* rather than *led by* that of the evaluator
- **verifying** data and interpretations with those involved
- **embedding** the evaluator in the process, through attendance at a number of steering group and all-site meetings.

3.2.1 Data sources

Based on the principles above, the evaluation has been grounded on the following data:

- Quarterly progress reports produced by the sites. These advise what actions have been undertaken that quarter, as well as containing reflections on barriers to and facilitators of progress. These reports were received between January 2010 and March 2011, and a final six-month report was submitted for the period April to September 2011.
- Quarterly summary reports written by the practice development managers working with the sites.
- Notes from all-site meeting discussions, including meetings at which evaluation findings were presented.
- The results of a consultation with steering group members in the sites undertaken as part of the development of *At a glance 32* (SCIE 2010).
- Notes and reflections from the practice development managers.
- The original practice survey conducted in the five English sites (baseline of practice compared to recommendations).
- Mapping of all site activities against the recommendations, undertaken by the practice development managers in collaboration with representatives from the sites.
- Data from practice examples written by the practice development managers and the research analyst in collaboration with representatives from the sites.

3.2.2 Data analysis

The first five sources of data listed above have been analysed thematically using the computer-aided qualitative data analysis software called Atlas Ti.

The mapping and practice examples have been used as the basis for describing the practice and initiatives undertaken in each site.

All data have been analysed with respect to the recommendations in the original guide and the findings of the systematic reviews and practice survey.

3.3 Limitations and challenges

There are a number of limitations to this evaluation, which are detailed in the sections below.

3.3.1 Exploring the impact on service users

As noted above, this project bore many of the hallmarks of a complex intervention in that there was significant local tailoring, interventions could take place at a number of points in the system and, correspondingly, with various outcomes for the service users involved. For example, different outcomes would be expected for changes to practice within a psychiatric hospital setting, compared to a children's centre.

Exploring impact was therefore extremely challenging: it was not possible to impose a single evaluation structure on all the various activities being undertaken by the sites, nor did we have sufficient resources to conduct tailored evaluations of each aspect of implementation. As a result, this evaluation has largely not been able to consider the impact of the interventions on service users and their families – a serious limitation. As the guide is based on evidence about what works for service users, we have reason to expect that implementing its recommendations will improve outcomes. However, this evaluation has not been able to provide further evidence for this.

3.3.2 Data sources

Many of the primary data sources are written summaries of meetings, rather than verbatim transcripts: it simply would not have been feasible to record and transcribe the huge number of steering group and sub-group meetings that took place. However, where possible, verbatim quotes have been included in written records, and in this report.

4 Implementing the guide: practice and initiatives

This section evaluates how sites have implemented the guide through changes to ongoing, day-to-day practice and/or short-term initiatives addressing one or more of the recommendations.

For each section of the guide, this part of the report:

- **describes what the sites did** – providing details of the approaches taken across the sites to implement the recommendations
- **considers progress against the recommendations** – what progress has been made across the sites, where possible using the original practice survey as a baseline
- **highlights new areas of practice** – things that the sites have tried which weren't recommended in the original guide
- **outlines remaining challenges** – areas of practice in which the sites either did not attempt to make changes, or attempts were unsustainable or unachievable, and the reasons for this.

4.1 Overarching themes

4.1.1 Target groups

As noted in Section 3.2, the guide was designed to be applicable to 'Staff in mental health and children's services from all sectors' (SCIE, 2009, p.1). By extension, this means that the service user groups targeted could also potentially be in mental health and children's services from all sectors. However, in practice, the majority of activities in the sites have focused on what might be considered the medium to high level of need:

- practice affecting families who are known to either statutory children's social care services, community mental health services, or both
- practice affecting those who do not quite meet the thresholds for statutory or secondary services, but nevertheless are adversely affected by parental mental ill health.

Sites have focused to a lesser extent on the highest levels of need, for example children who become looked-after because a parent has been hospitalised. In some cases, the focus on the slightly lower levels of need was a conscious decision, as it was felt that arrangements for working in these crisis situations were clearly laid out. In contrast, working arrangements were weaker when issues for families were less clear cut, for example where either children or parents did not meet the thresholds for statutory/secondary services.

There has also been slightly less focus on families using universal services such as general practitioners (GPs) and schools. Having said this, several sites moved more into this area as the project went on, and began to engage more extensively with education in particular. The Northern Ireland sites took a particularly broad perspective

and included services such as school and public health nursing in their change programme.

4.1.2 Improvement of existing services

The recommendations of the guide focus on making improvements to the way existing statutory and voluntary sector services work together to support families, rather than establishing new services. The activities in the sites were very much aligned with this, with a focus on working to improve the existing service network rather than creating new structures or teams. There were a couple of exceptions, where new posts were set up within existing teams – for example, embedding family support workers in CMHTs.

As noted in Section 2.4, this differs from other recent projects designed to support families with complex needs, such as the FIPs, which have involved establishing new multi-agency teams with a dedicated caseload.

4.2 A strategic approach

The guide highlights the importance of taking a multi-agency, strategic approach to improving services for parents with mental health difficulties and their children. In particular, it emphasises the need for support from senior managers, and the development of an agreed strategy to structure the work.

4.2.1 What the sites did

The sites provided strategic direction to the implementation of the guide in a range of ways:

- overarching think family strategies
- establishing project-specific governance arrangements and securing ‘sign-up’
- communication strategies
- workforce development strategies
- assessing and measuring performance
- embedding in restructured services

Think family

Two of the English sites (Southwark and Liverpool) had already developed a local think family strategy as part of their existing work to improve services for parents with mental health problems. These set out the local aspirations and priorities, and strategic plans for continuing to improve services for this group. In Southwark the strategy was updated and re-circulated. In Liverpool an appendix to the main family strategy specifically relating to multi-agency approaches to mental health and child welfare was produced.

A number of sites included think family principles within more general strategies, such as the Northern Ireland **Service Framework for Mental Health and Wellbeing**, or in their children and young people’s plan (CYPP) (Southwark).

Establishing governance and securing 'sign-up'

In all the sites, work on this project was guided by specific strategy and governance arrangements. All the English sites produced an implementation plan outlining which of the recommendations they would tackle, and how. In Northern Ireland, the project managers produced a regional implementation plan, which was then translated into local plans by the local project teams.

In terms of governance, each English site established a steering group to lead the work on the project, with representation from the mental health trust, children's services and (in most cases) the voluntary sector/service user representatives. The sites then sought sign-off for this work either from their family strategy board or the local Safeguarding Children Board (SCB). The exception was Liverpool, where it was felt there was sufficient seniority within the project steering group itself.

In Northern Ireland, the project was overseen by a regional project board, which also signed off and provided governance for the work. Local implementation was led by a project locality team in each of the five health and social care trust areas. All regional and local initiatives were supported by two project managers who were employed to manage the development of think family recommendations.

These arrangements helped to ensure multi-agency collaboration for the implementation project. In two sites (Liverpool and Southwark) that had existing groups this will continue after the implementation period. In three sites (North Somerset, Lewisham and Birmingham) the function of the group will be continued by another group.

Communication strategies

The guide highlights the importance of communicating:

- with staff, to raise awareness of think family issues and to encourage changes to practice
- with children and families, to help reduce the stigma surrounding parental mental illness.

In Liverpool and the Northern Ireland region communication strategies were developed which aimed to co-ordinate communication with both staff and families. These were implemented in a variety of ways including:

- regular updates via website and newsletter
- information about the website sent out with staff payslips
- development of posters and aide memoires for staff and service users to raise awareness about think family issues.

More information about the Northern Ireland communication strategy is shown in Box 2.

Box 2 Northern Ireland communication strategy

The aim of the strategy was to:

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

The strategy co-ordinated the messages that the project was sending with existing health promotion activities relating to mental health and children's services within the relevant organisations, such as the trusts, the National Society for the Prevention of Cruelty to Children (NSPCC), Action Mental Health and Action for Children.

The strategy helped to establish a regional public information campaign to support mental health and reduce stigma. This information was presented in the local press, and made links with other events – for example, No Smoking Day, Mental Health Day, Defeat Depression Day and national campaigns. A series of monthly press releases on relevant topics was established.

Information was also placed in clinic settings, GP surgeries and on hospital TV banners to promote positive messages about mental health, staying healthy and getting help, providing information for individuals and their families on how to access services.

The strategy ensured that the trusts included a signpost to the 'Mind your head' website and links from each trust intranet site to the HSCB's 'Think Family Project' web page. The project web page included additional local information relating to the project such as local contacts, events and changes to service delivery. Similarly, Aware Defeat Depression set up a hyperlink between the trust and voluntary organisation pages and the HSCB web page.

Workforce development strategies

During the project, three sites (Northern Ireland, North Somerset and Liverpool) developed strategies to co-ordinate workforce development in relation to think family issues. These set out plans for embedding think family in existing training, and rolling out new relevant training opportunities.

In Northern Ireland, a knowledge and skills framework was developed. This aimed to structure planning, commissioning and delivery of training to meet the learning and

development needs of staff working across the mental health and children's services interface. The framework also aims to:

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

The framework covers five 'domains' of practice: promotion of positive health and well-being; communication; safe and effective care; signposting/improving access to services; and intervention. It also identifies three levels of complexity at which different types of professionals may be working:

- **Foundation** – 'working together to identify and signpost to services for support when required'.
- **Secondary** – 'working together to identify and assist parents with mental health issues and promote the wellbeing of their children and families'.
- **Advanced** – 'staff working predominantly (responsible for the treatment and management of care) with adults with mental health issues and/or their children and families. Those who require the knowledge and skills to manage risks effectively across mental health/children's services interface. Those who have particular responsibility or organisational authority and a substantial degree of autonomy to act in the best interests of parents/children at this interface'.

For each of the domains of practice, the framework provides a detailed set of competences for professionals working at the interface of adult mental health and children's services.

Assessing and measuring performance

The guide recommends that local implementation begins with a review of existing provision, to highlight particular gaps and areas of need. The practice survey undertaken by SCIE in the English sites provided a starting point for this. However, the Liverpool site undertook an additional audit of practice, and several other sites undertook consultation and engagement events to gather views more widely about current discrepancies between practice and the recommendations in the guide.

A number of sites have undertaken evaluations of specific projects and initiatives. This is extremely positive and in line with the recommendations of the guide. Liverpool has conducted two reviews of an existing project to establish 'family rooms' in all inpatient services within the trust (Mersey Care NHS Trust 2011, 2012a). These provide a space for children to spend time with their parents away from the main ward. The reviews consulted both children and parents about their satisfaction with these facilities. Other

evaluations were also conducted by Liverpool (Mersey Care NHS Trust 2012b) and Southwark (Webber et al. 2011) and are discussed further below.

The guide also highlights the importance of establishing a set of indicators that would help to measure improvements in services and outcomes for parents with mental health problems and their families. This proved to be challenging for most sites: current recording systems do not support obtaining data about parents with mental health problems and their children (see Section 4.5). The Northern Ireland project managers were able to develop a set of performance measures and indicators for measuring progress in improving outcomes for parents with mental health problems and their children. However, these relied on bespoke data collection, in particular from their family experience survey (see Section 4.3).

Embedding in restructured services

A number of the sites underwent restructuring of social care or mental health services during the course of the project. In North Somerset, think family principles were embedded in the restructuring process. The restructure was termed 'Total Family' and looked at how savings could be made by having better co-ordinated, earlier interventions with families.

4.2.2 Progress against the recommendations

Compared to the practice survey, the sites made progress in terms of producing or updating strategic plans, and in some cases linking these to wider, related plans.

The sites were also successful in achieving multi-agency collaboration between mental health and children's services, although some struggled to achieve what they felt was the necessary seniority of leadership within their project steering groups. As noted in the interim evaluation report (SCIE 2011), there were some important professional groups that were not generally represented on (particularly the English) steering groups, including GPs and schools.

Working in partnership with parents and families was also highlighted as a key part of the necessary strategic approach. This is discussed in Section 4.3.

4.2.3 New areas of practice

The development of a knowledge and skills framework in Northern Ireland is extremely positive. One of the literature reviews underpinning the guide identified that there was little material which 'focused in depth or detail on the skills, values or knowledge needed for this area of work [working with parental mental health and child welfare]' (Stanley and Cox, 2009 p.77). The detailed competence framework that has been produced is therefore a valuable addition to guidance in this area.

4.2.4 Remaining challenges

Measuring and monitoring overall progress remains challenging, in particular measuring outcomes for families rather than service outputs (e.g. proportion of cases in which child risk screens are completed).

Several of the performance measures for the Northern Ireland sites rely on the family survey, as well as other specific surveys and case audits, which will be supported by a regional audit resource. Applying this approach in England would therefore require

availability of similar resources. In England this therefore remains a priority for development, which may require a national approach. However, as government reduces statutory reporting and aims to increase local flexibility, there may now be more opportunity for local areas to establish their own indicator data.

4.3 Involving service users

The importance of involving service users in the design and delivery of services is highlighted throughout the guide. A separate section on this topic is included here because many of the activities cut across different stages of the care pathway.

4.3.1 What the sites did

Activities to involve service users in the sites included:

- service user representation on project steering groups
- user consultation
- survey of service users
- development of educational materials by service users.

Service user representation on project steering groups

The majority of sites had either service users, service user representatives or both on their steering groups. This allowed the implementation plans to draw on knowledge of what service users find acceptable. Most service user representation was from the parent/adult mental health side, with the exception of Liverpool, which has extremely well-developed links to a young carers project, and the Northern Ireland steering group, which had substantial representation from children and young people's service user groups. One site had no service user involvement as networks were not well developed in that area – this remains an outstanding priority.

User consultation

Several sites (Lewisham, Southwark, the Northern Ireland region) have undertaken specific consultation with service users. Early on in the project, Lewisham recognised that it lacked an organised user group of parents with mental health problems. This meant that the work risked being done without the input of the people it was designed to benefit. A consultation group was therefore established during the course of the project, as described in Box 3.

Box 3 Lewisham user consultation group

The aim was to provide a forum where parents with mental health problems could give their views on the implementation project and advise the steering group on the acceptability of the changes they were suggesting.

The steering group in this site identified parents with mental health problems from within existing user groups and mental health forums. A flyer was produced to explain the nature of the proposed service user group, and the work it would do. It was made clear that people would be paid to attend, from funds set aside to support the think family project.

Twelve people agreed to join the group. A local facilitator, herself a mother with mental health problems, was engaged to run it, alongside a manager from a voluntary sector scheme that supports families affected by parental mental ill health. A local children's centre was identified as a suitable venue.

The user group was set up specifically to advise on the work of the think family project, although it was hoped from the start that it would have therapeutic benefits and in time address the wider issues the parents faced. Initially, eight meetings were scheduled, with each one focused on a particular aspect of Lewisham's think family action plan.

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

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

Survey of service users

In Northern Ireland, the project managers worked with an independent consultant to develop a family experience survey. The questions for the survey were developed in consultation with a panel of service user representatives from voluntary and support organisations. The survey involves families narrating their experiences and then rating their overall experience according to a number of three-point scales, for example:

How did you feel about support from services?

- There when we wanted
- Not what we needed
- Difficult to get

The narratives and rating scales were analysed and presented using a software package called Sensemaker. A first round of the survey was completed by 58 service users.

Development of educational materials by service users

In Southwark, parents attending a parents' forum established in partnership with Southwark MIND were instrumental in developing a staff training film, *Nobody says congratulations*. The film aims to show service users and parents in their own homes, surrounded by the paraphernalia of family life. Through the stories of three parents with mental health problems, it provides clear messages for staff about how parents want to be supported.

4.3.2 Progress against the recommendations

The guide recommends that parents, children and carers are involved in all stages of implementing its recommendations. The sites had different starting points for achieving this: some had well established service user groups, who were represented on the project steering groups; in other sites there had been less of a history of service user involvement, and so there were fewer established networks. Some of those sites made good progress in establishing networks during the course of the project.

4.3.3 New areas of practice

The Sensemaker tool used in Northern Ireland is an innovative way of engaging with families, enabling them to tell their 'story' but also recording it in a standardised format to assist in the identification of themes and patterns, and providing a tool for measuring progress.

The film produced in Southwark was also an innovative way of allowing practitioners and managers to hear the perspectives of parents with mental health problems.

4.3.4 Remaining challenges

A number of sites proved less successful in involving children than involving parents or carers. There was evidence from one site that parents were reluctant for their children to engage with services, even to be consulted, presumably due to the stigma and fear attached to this. However, this site did still successfully run a consultation day for young carers. The Northern Ireland region site was also successful in gathering the views of a small number of children and young people using the Sensemaker approach.

4.4 Workforce development

Training and workforce development is crucial to the recommendations of the guide in terms of providing staff with the skills required to put think family into practice.

4.4.1 What the sites did

There were a range of workforce development activities including:

- awareness-raising
- inclusion of think family in other training
- training courses specifically relating to working with parents with mental health problems and their families
- 'practitioner champions' groups

- use of SCIE elearning materials
- liaison with HEIs.

Awareness-raising

A number of sites have held awareness-raising events with frontline staff, managers and service users. The aim was to inform people about the project, raise awareness of a think family approach and consult on the content of the implementation plan. In Birmingham, a think family conference was held covering a number of strands of work (e.g. parental mental health, substance misuse and so on) and attended by representatives from a range of organisations. The Liverpool site ran a series of 'lunchtime learning' sessions (see Box 4).

Also linked to this has been liaison with key staff groups such as those working in statutory children's services or CMHTs, which has been carried out in several sites. The purpose of these meetings has been to remind people of the importance of working practices that support a think family approach – for example, completing child in need risk screens. In some sites, members of staff such as safeguarding leads routinely do this as part of their job.

The Liverpool and Northern Ireland sites have produced posters to help raise awareness among staff about parental mental health issues. Liverpool aimed these at schoolteachers, to raise awareness about young people who might be caring for a parent with a mental health problem. In contrast, the Northern Ireland project managers commissioned general think family posters aimed at staff in a range of services for both children and adults.

Box 4 Lunchtime learning sessions

Liverpool held a number of lunchtime learning sessions for staff from a range of agencies. The sessions were held at eight different locations across the city. The aim was to introduce staff to the guide, and show how it was going to be implemented locally. The sessions were delivered to multi-agency staff groups, so that they were also an opportunity for staff to meet and network with one another.

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

- the local authority
- the NHS foundation trust
- the mental health trust
- the community and voluntary sectors
- the primary care trust.

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

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

Inclusion of think family in other training

A number of sites amended existing training opportunities so that think family issues were covered. This was largely in terms of raising awareness of the issues, rather than providing people with specific skills in working with families affected by parental mental ill health.

For example, in Liverpool, the two-day induction programme for all social workers across both children's and adults' services now includes a one-hour session on parental mental health and child welfare. Lewisham and Birmingham have included think family as part of their mandatory safeguarding training.

Bespoke think family training

Some sites have commissioned training specifically aimed at improving workers' knowledge and skills in relation to children and families.

In Southwark the family strategy group commissioned the Centre for Parent and Child Support to train adult mental health practitioners using the **family partnership model** (FPM) (Davis et al, 2002). This model had previously been used largely for professionals working primarily with children and families. The model was therefore adapted for use with adult mental health staff.

The training was evaluated to assess participant reactions and the impact these had had on their practice. Initial reactions and perceived changes in attitudes, skills and knowledge were evaluated using self-completion questionnaires at the end of the training. Interviews were also conducted with nine practitioners who had taken part: six from the first cohort and three from the second cohort. These were undertaken approximately 18 and 6 months respectively after the training had been completed.

Focus groups were held with parents to discuss their perceptions of practitioners' practice following the training. Recruitment for the focus groups proved challenging for both cohorts. However, following a mailing of all service users of the team involved in the first cohort of training, two focus groups were held. For the second cohort it was not possible to convene groups, so individual interviews with parents were held instead.

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

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

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

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

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

In North Somerset a safeguarding conference was held, aiming at highlighting the impact of parental mental health on children and young people. A local theatre group, **Eyewitness Theatre Company**, facilitated the day. Sixty delegates attended from a variety of agencies including schools, AMHS, adults' and children's social care, youth offending teams, solicitors, health services and the voluntary sector.

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

Feedback from the event was overwhelmingly positive, and to try and ensure that what was learned made an ongoing difference, delegates were asked to feed back four months after the event. All said they had been able to put their learning into practice.

One site commissioned nine sessions of **training for adult mental health and children's social care staff**, looking at the practical applicability of whole-family approaches in mental health. Managers had a separate training session, to encourage their acceptance of and participation in the new ways of working.

Practitioner champions

To improve joint working between practitioners, the North Somerset site established a 'practitioner champions' group. The terms of reference were as follows:

- **highlighting best practice** in joint working between services
- **learning lessons** from serious case reviews, to link with the local SCB and follow through lessons with practitioners
- **developing mutual understanding** and knowledge across statutory services
- **furthering information exchange** across agencies regarding resources, law, eligibility thresholds and practice developments
- **highlighting unmet need** and identifying services that may be available
- **discussing specific cases**, providing peer review, highlighting problems and **previewing implementation** of joint protocols when formally adopted by the SCB, ensuring they are widely disseminated across teams in all relevant services
- **acting as a link with teams** – 'champions' to take these issues back to their teams, and to bring issues to the group from their operational unit
- **fostering a think family approach** in accordance with research findings and in conjunction with the SCIE project team.

The group meets once every two months and is attended by frontline practitioners from a number of services across adult mental health and children's services. There are currently around 20 members, representing four main staff groups, as shown in Figure 7.

Figure 7 The four North Somerset staff groups represented at the practitioner champions group

<p>Children’s services locality teams</p> <ul style="list-style-type: none"> • Education welfare • Education family support • Assistant locality leader • Mental health worker • Parenting co-ordinator • Children’s centre staff 	<p>Children’s services specialist teams</p> <ul style="list-style-type: none"> • CAMHS • Youth offending team, children’s social care
<p>Adult mental health – primary</p> <ul style="list-style-type: none"> • Positive Steps • Wellness adviser 	<p>Adult mental health – secondary</p> <ul style="list-style-type: none"> • CMHTs • Community psychiatric nurse • Mental health social workers • Family therapist • Lead professional

Since it was established, the group has:

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

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

- collect examples of families falling through the gap between AMHS and children’s services, to feed back to their respective clinical governance groups
- share more examples of good practice

- undertake job shadowing and 'buddying' to better understand each other's roles.

Following the success of this group, a similar model has been adopted in the Northern Trust in Northern Ireland, and there are plans to establish one in Southwark.

Use of SCIE elearning materials

During the course of the project, SCIE produced a suite of elearning materials about various aspects of taking a think family approach to parental mental health and child welfare.

Some sites have actively promoted the use of the elearning materials, including in Northern Ireland where GPs have been encouraged to complete the elearning modules as part of their continuing professional development.

Liaison with HEIs

In Northern Ireland, the project managers made links with the two universities in the region to discuss ways of incorporating think family into under- and postgraduate training courses. The consultation on the draft knowledge and skills framework also included representatives of higher education in social care, mental health, nursing and medicine.

4.4.2 Progress against the recommendations

Our original practice enquiry found that there was a 'substantial unmet need' for training about parental mental health and child welfare.

The sites have now gone some way to addressing this, and have provided training specifically about the issues concerning parents with mental health problems and their children, as well as making explicit the links between more 'generic' training – for example, safeguarding training – and this service user group.

Most sites took a strategic approach to embedding think family in workforce development and in two sites (North Somerset and Liverpool) the workforce development manager or equivalent was a member of the steering group.

4.4.3 New areas of practice

Given current constraints on resources, the 'embedding' of think family concepts in existing or mandatory training was a particularly promising development. Although these training opportunities may not cover as much as a specific training course, they are less vulnerable to funding cuts than specially-commissioned bespoke training.

The guide particularly recommends joint training between AMHS and children's services' staff. While this clearly plays an important role, some training participants also saw a value in training which is delivered on a single-agency basis, as this allows people to ask what they see as the 'stupid questions'. Some participants suggested a mixed model, in which some sessions of a training course could be delivered to single agencies and some to multiple agencies. While we would continue to recommend joint training wherever possible, it is important to recognise that some value can be gained from single-agency training.

4.4.4 Remaining challenges

Although the sites showed an improvement in the availability of relevant training during the project, some parental mental health-specific courses are vulnerable to being cut due to lack of funding. It will therefore be a challenge for all sites to continue to commission some of the more specialist training programmes. No sites tackled the recommendation of a leadership programme for supervisors and managers. Again, this may be linked to the difficulties associated with commissioning new training at this time.

A number of the recommendations in the guide were about professional and post-qualifying training. Because some of the Northern Ireland implementation was carried out on a regional basis, the project managers were able to liaise with HEIs to discuss implications for this. Although some of the English sites have good relationships with local universities, it was largely outside their control to influence professional and post-qualifying training. This therefore remains an area for development in England.

4.5 Improving access to services

The original guide found that families with a parent with mental health problems often fall through the service net because:

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

4.5.1 What the sites did

The sites took a range of approaches to trying to improve screening and identification of parents with mental health problems. These came under three main types:

- tools to assist workers in asking the right questions
- cross-referencing electronic databases to establish whether families are known to mental health services
- exploring technical solutions to linking electronic databases.

Tools to assist workers in asking the right questions

In Northern Ireland, services collaborated to develop a **standardised form of words** for workers to use when gathering information from parents with mental health problems. A range of services were asked to review their current screening and assessment

templates, including addictions, maternity, health visiting, accident and emergency, mental health, children's social work services and voluntary organisations, and involved inpatient and community services. Gaps and examples of good practice were identified and shared.

A shared form of words was then developed which investigated:

- What is the family composition (e.g. name, relationship, age/date of birth, occupation/school/nursery)?
- Does the mental health of parents/carers impact upon children and family life/routines?
- If so, what is the impact (provide details)?
- Is there a child/young person undertaking caring?

Southwark worked in particular on their **child in need risk screen**. This is a local tool for adult mental health workers to record information about children of parents with mental health problems, and to conduct an initial 'screening' assessment about likely risks to the child. At the beginning of the project, completion rates of the risk screen were relatively low. In consultation with staff the wording of the screen was simplified and amended. Response rates have now increased.

Cross-referencing databases

The incompatibility of electronic databases in children's social care and adult mental health services remained a challenge throughout the project. However, the Birmingham site was able to develop a process for cross-checking databases, on a case-by-case basis.

When there is a child protection inquiry (also known as a Section 47 inquiry), a staff member from children's social care will automatically check with AMHS to see if any members of the family are known to them. A similar check is made when an adult is referred to Birmingham's mental health home treatment team. At that point children's social care services are contacted to see if they have knowledge of the family. Referrals to the home treatment team were chosen as a trigger because the numbers were felt to be manageable for staff, while still capturing people likely to be living with children.

The site undertook substantial preparatory work, liaising with local Caldicott guardians (National Health Service – NHS – professionals responsible for managing the confidentiality of patient information) and their children's social care equivalents to make sure that the checks did not breach the rules on information-sharing. For children's services, making checks at the point of a Section 47 child protection inquiry is not an issue. Section 47 is a significant threshold for a case to reach, and information-sharing about a family becomes paramount.

Inspired by these developments, Lewisham has also included a similar process in its joint working protocol, namely adding AMHS to the list of agencies to check when a Section 47 investigation is initiated.

Exploring technical solutions

The approach above requires a manual check of an electronic database as part of a Section 47 inquiry. However, it does not resolve the underlying problem of incompatibility between children's social care and AMHS. Liverpool convened a group of data analysts from across AMHS and children's services to look at possible technical solutions for linking up information across the two recording systems. However, the group was not able to find a satisfactory solution. This was partly due to the decision-making power of those within the group – it seemed that more senior leaders needed to be involved in the discussion in order to resolve this issue.

4.5.2 Progress against the recommendations

Taken with the workforce development activities and awareness-raising described above, most sites were able to make progress on developing or improving tools for screening. Unfortunately, it was not possible to assess the impact of improved screening on outcomes for parents and families – this would require a longer time frame than is possible within the scope of this evaluation.

It was interesting to note that most of the changes to screening focused on identifying mental health service users who are *parents*. There were fewer initiatives focusing on identifying parents of *children* known to children's social care who might be suffering from mental health problems. Our original literature review (Parker *et al.*, 2009) pointed out that simple screening tools for depression are in use in the USA, but there was less evidence from the UK.

Further research conducted by SCIE after publication of the guide found that where mothers (we found no evidence on fathers) have been screened for depression, they have usually not sought help, even when they said they would (Needlman *et al.*, 1999); (Shakespeare *et al.*, 2004). This suggests that it was more appropriate for sites to take the approach they did – focusing their efforts on identifying parents among mental health service users rather than screening children's social care users for mental health problems.

4.5.3 New areas of practice

The guide recommended that organisations provide staff with tools to enable them to ask the right questions. It was encouraging that the Northern Ireland sites took this a step further and produced standardised screening questions across a wide range of agencies. This should have benefits in terms of services referring and signposting to each other.

4.5.4 Remaining challenges

Use of databases

Our original practice enquiry highlighted the difficulties sites had in producing data on how many adults using mental health services are parents. This problem has remained in all the sites, and activities such as auditing numbers of parents have had to be conducted manually.

Part of this problem is to do with the software used to record information about users of mental health services. Individual sites have little power to change this software, which is provided 'off the peg'. SCIE has consulted with data specialists who suggest that service providers using particular software packages would need to act collectively to lobby the software provider to introduce changes: this was outside the scope of the project.

There is also a problem with allowing data to be cross-referenced across systems. Experience from our project, and similar projects such as FIPs, is that this generally has to be conducted manually on a case-by-case basis, rather than via a systematic linking of the two systems. This is an area in which national-level changes would be helpful.

Meeting the demand uncovered by screening

Improving access to services is beneficial in terms of providing support to the families who need it. However, it does raise the issue of how local areas will respond to a potential increase in demand, particularly at a time when services are being cut. Clearly, if families are in need of support, then it is right that this need should be identified and met. However, in some sites there is a perception that a think family model will lead to an increase in children in need referrals, which has implications for already stretched services. Despite this, we would encourage local services to continue to champion a think family approach, as this is the only way to reveal the true extent of need and suitable resources.

4.6 Assessment

Our original guide highlighted problems with assessment, particularly with regard to:

- gaining a holistic picture of family needs
- taking into account strengths as well as areas of concern
- making appropriate judgements about risk.

4.6.1 What the sites did

The main activities in this area were:

- amendments to assessment tools
- clarifying thresholds for assessment
- clarifying care pathways
- using the CAF to support families affected by parental mental ill health.

Given the importance of practitioner knowledge about other services, and how to share information, some of the workforce development activities highlighted above should also have a positive impact in this area.

Amendments to assessment tools

The Northern Ireland sites were the only ones to amend existing assessment documentation. Because the project was operating at a regional level, they were able to review and amend region-wide documentation, whereas the English sites could not make changes to nationally standardised screening and assessment tools.

In Northern Ireland, the UNOCINI assessment tool is a comprehensive assessment process used regionally. It is also used as the basis for referrals to statutory children's services to identify the needs of children, based on 12 domains. A review of the UNOCINI guidance for staff highlighted that parental mental health wasn't explicitly covered. The guidance did not provide for the detailed elements of parental mental health that staff need to consider when completing a parental assessment. Nor did it consider the factors such as nature of illness, compliance with medication, frequency of illness, insight into condition, insight into children's needs, support that is available to the family, and so on.

A working sub-group was formed which included representation from relevant agencies and services who were tasked with writing an addendum to be added to the guidance. Crucially, this included frontline workers who would be using the assessment form. This was then tabled at the regional reform implementation team for approval and subsequently sent to the DHSSPS for authorisation.

The project locality teams in Northern Ireland also set out detailed plans for amending a range of assessment forms across services to ensure that they reflected think family principles. At the time of writing, this was ongoing. Work continues to be progressed by a regional education sub-group which is considering from a think family perspective the screening and assessment tools currently being used in education psychology, education welfare, education other than at school (EOTAS) and counselling. Voluntary sector participants continue to work on strengthening screening and referral process to gather information on the impact of parental mental health.

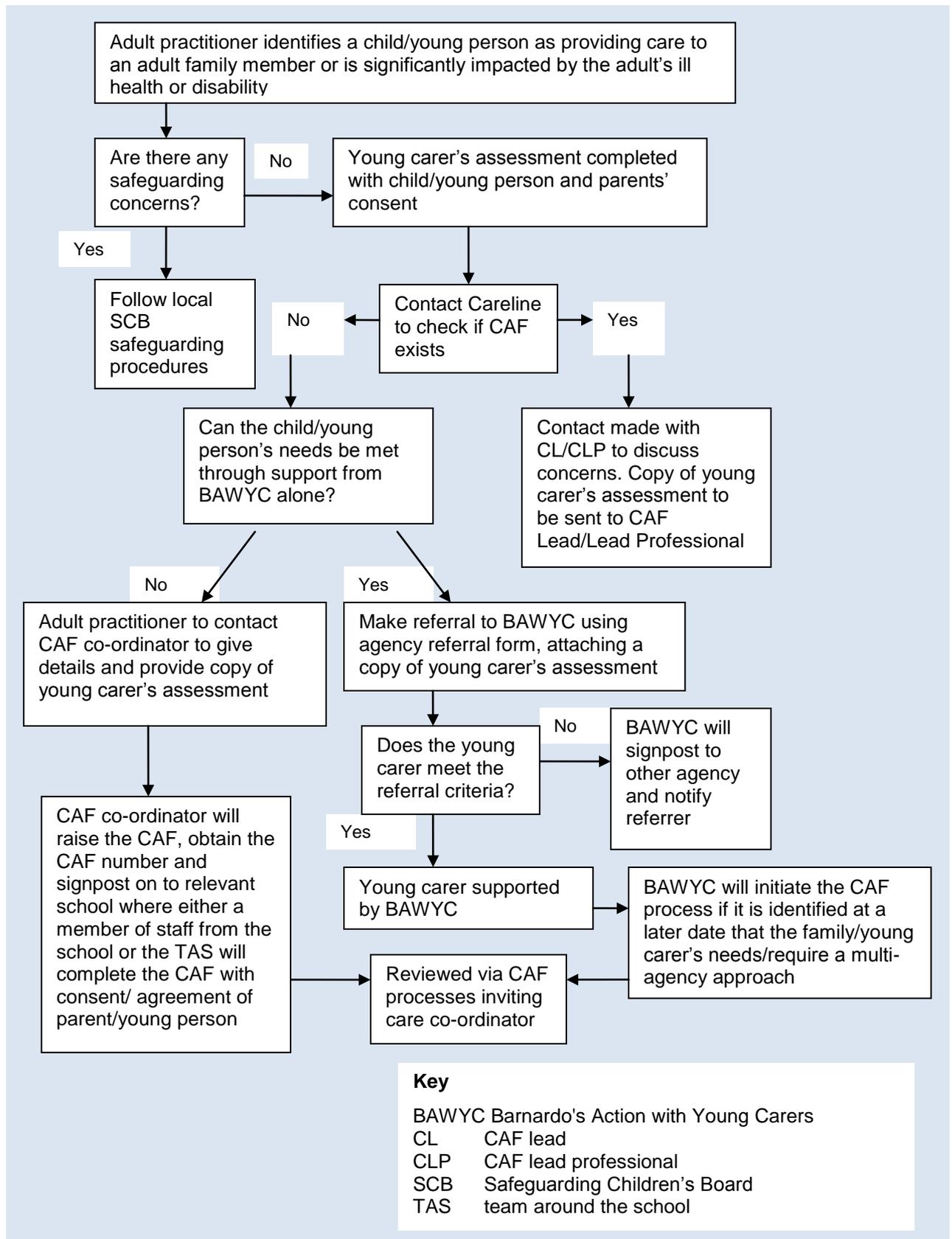
Clarifying care pathways

In Liverpool it was shown that there was a lack of clarity regarding assessment and referral of young carers who were identified by staff in adults' services. The care pathway for young carers was therefore revised in order to:

- clarify the process for assessing and referring young carers
- make links with the CAF and team around the school (TAS) processes
- facilitate young carers' access to support services such as education welfare, educational psychology, outreach support and Barnardo's Action With Young Carers (BAWYC).

The site developed the care pathway shown in Figure 8.

Figure 8 Young carer's care pathway



Involving the CAF co-ordinator was key to ensuring successful integration of young carers' assessments and CAF. Training is needed to support workers in putting the new pathway into practice.

Using the CAF

Linked to the care pathway, the Liverpool site has undertaken work to enhance the contribution of the CAF process to supporting families affected by parental mental ill health. This has been in two main ways:

- providing staff from adults' services (including AMHS) with training on thresholds of assessment in children's services, and on the CAF and pre-CAF processes
- piloting the use of the pre-CAF in one CMHT.

The aim of the training was to enable practitioners to:

- understand how the local SCB guidance on service thresholds and assessments is to be used by practitioners, professionals and agencies
- use the SCB guidance to improve the quality of referrals, ensuring they are appropriate, necessary and timely
- understand how the CAF is used and how it can be embedded in the practice of children, family and adult services
- understand how the CAF for children and young people is to be implemented in a whole family approach.

The training therefore covers the current work related to think family in the area, an explanation of the four-level thresholds of need framework and an introduction to the CAF and pre-CAF processes.

A local analyst conducted an evaluation of the training. Staff responses immediately after were as follows:

- nearly all (98 per cent) respondents agreed that the event increased their knowledge and understanding of the local SCB guidance on the four levels of need
- 96 per cent were very or fairly confident that they had the skills/competencies listed in the questionnaire to enable a family centred approach
- overall, 98 per cent were satisfied that the event provided enough guidance to put the family centred approach described into practice.

The Liverpool site has also piloted the use of the pre-CAF assessment in one CMHT. Unfortunately, the results of this pilot were not available at the time of writing.

4.6.2 Progress against the recommendations

The guide suggests that local areas examine assessment processes and eligibility criteria to ensure that they take account of the family's needs.

Only the Northern Ireland sites were actually able to amend assessment documentation to reflect this. The English sites reported that they were not able to make changes to assessment documents, many of which are standardised at a national level (e.g. the core assessment in children's services).

Similarly, sites were not able to amend the eligibility criteria for local statutory services so that circumstances relating to the family as a whole would be taken into account when deciding whether to accept a referral for an individual from that family. Often, eligibility criteria have a statutory basis (e.g. meeting definition of child in need) which individual sites were not able to address. However, what Liverpool was able to do was:

- Champion the use of the CAF for supporting families affected by parental mental ill health. This assessment is specifically designed to encourage a holistic approach to assessing and supporting families.
- Improve access to non-statutory support services, again via the use of the CAF and team around the family (TAF) processes.

As noted above, a range of skills and knowledge underpin assessment. Therefore, general training and workforce development activities should have a positive impact on the quality of assessment, as well as activities specifically in this area.

Socially inclusive approaches to assessment

It is not clear to what extent the sites have been able to address the recommendations relating to socially inclusive approaches to assessment, or to ensuring that assessment considers strengths and resilience factors as well as problems. The use of the CAF may address this to some extent, as the assessment form encourages workers to present strengths as well as needs. However, more detailed exploration of frontline practice would be required to ascertain this.

4.6.3 New areas of practice

Looking beyond individual workers' practice

The recommendations concerning assessment in the guide focus on individual staff practice. The experience of the practice sites has shown that organisational factors are also important, in particular the tools that workers have available to them and the use of non-statutory assessment and referral care pathways such as the CAF for accessing family support.

Use of the CAF by adult mental health staff

Encouraging staff in adults' services to use the pre-CAF, CAF and TAF processes is a development which is not specifically recommended in the guide. However, this would be a promising area of practice, making use of existing infrastructure to integrate children's and adults' service responses, although it is important to take into account the varying extent to which the CAF and TAF are embedded across England (Easton et al. 2010). More work needs to be done to explore the use of this process by adults' services, including AMHS.

4.6.4 Remaining challenges

The experience of the sites suggests that there are a number of challenges remaining with regard to assessment.

Information-sharing

The incompatibility of information technology (IT) systems across services identified above has implications for assessment. A good assessment will gather information from the range of professionals already involved with a particular family. However, the difficulty in cross-referencing different service databases can prevent identification of which services are involved, particularly if parents do not disclose this information.

Mental health assessments and the CPA

Most of the changes to assessment forms and processes in the sites were in relation to assessments that are primarily based within children's services. None of the sites focused on assessments that were primarily based within mental health, such as the CPA. The reasons for this are not clear. However, our initial literature review highlighted that care programme planning meetings should be an opportunity for identifying children's needs (Stanley and Cox, 2009). It may therefore be fruitful for local areas to further explore how *all* these processes can be improved to incorporate a think family approach.

4.7 Planning and reviewing care

The guide makes a number of recommendations as to how care planning can take a more holistic approach, taking into account the needs of individuals as well as the whole family. It places *equal emphasis* on the child, the adult (including their needs as a parent), the parent-child relationship and the family. It emphasises the need to consider the impact of a parent's treatment or intervention on their children. This is particularly important for children who are carers.

Although the guide has separate sections on planning and reviewing care, they are discussed together here as they should be complementary aspects of the same process. That is, in reviewing a care plan, a new plan is also made, based on the strengths and weaknesses of the previous plan.

4.7.1 What the sites did

As noted in the original guide, a good understanding of other agencies and strong relationships with other professionals underpins good joint care planning and review. A number of the workforce development activities described above, and the practitioner champions group, therefore potentially have benefits for this recommendation.

Activities to support this recommendation included:

- joint protocols for working between AMHS and children's services
- use of the CAF and TAF processes
- complex case discussions.

Joint working protocols

Lewisham and Southwark already had protocols outlining how AMHS, CAMHS and children's social care should work together to support families. Lewisham updated this during the project. North Somerset produced a similar protocol early on.

A protocol was produced by the Northern Ireland sites, making explicit reference to the SCIE guide, and with a slightly wider target audience including:

- adult services (acute hospitals and community health and social care services)
- learning and physical disability, sensory impairment
- maternity services
- primary health care services
- children's services including CAMHS
- AMHS
- substance misuse services including statutory community and voluntary services
- voluntary and community groups.

Trusts, voluntary organisations and project locality teams are working with the project staff to identify action plans for implementation of the protocol. This work has also been endorsed by the DHSSPS, which should help to support successful implementation.

Southwark evaluated the awareness and impact of the protocol by means of a cross-sectional survey of staff in children's social care and AMHS (Webber *et al.*, 2011). This study found that there was a high awareness of the protocol among staff (79 per cent of respondents). Staff also reported that the protocol improved awareness of risk factors for safeguarding children, and helped to improve service provision by clarifying roles and accountability. However, it should be noted that this survey had a low response rate from AMHS compared to children's social care.

The joint protocols from Northern Ireland, Lewisham, North Somerset, Southwark all make reference to co-ordinating care planning and review. Example points include:

- **Northern Ireland**
 - need for an initial joint planning meeting attended by all agencies and the family
 - changes to circumstances that will impact on current care plans must be communicated to staff or services involved in the family's care
 - case must not be closed unless all agencies/services are in agreement.
- **Lewisham**
 - staff should devise, with family members, a co-ordinated plan which addresses the needs of all family members, setting out the action to be taken, by when and by whom, identifying the outcomes by which effectiveness will be measured

- children and young people's participation in review meetings should be welcomed
- some adults and children may prefer to present for all or part of the review meeting, others may wish to participate more indirectly, by letter or email or by nominating someone to speak for them
- the use of advocates should be considered.
- **North Somerset**
 - the impact of any intervention on the ability to care safely for a child or effectively parent should be considered and recorded when planning care and treatment
 - information from CMHTs should be considered at children's strategy meetings.
- **Southwark**
 - agencies should always take into account the changing needs of adults and children
 - where more than one agency continues to be involved in a joint assessment or provision of services for parents or carers with mental health problems and their children, regular dates must be set to jointly review the situation and ensure that inter-agency work continues to be co-ordinated.

Use of CAF and TAF in English sites

The CAF and TAF have implications for care planning in that they potentially provide a forum for professionals from a range of services, both adults' and children's, to engage in joint planning and review of care packages. This could potentially help to address points in the guide relating to ensuring that the impact of any changes to the child's or adult's care on the rest of the family are considered.

Complex case discussions

In North Somerset, regular meetings were previously held between children's centre and health visiting staff to discuss cases with involvement from both agencies. During the project, these meetings were extended to include involvement from AMHS. This has allowed communication between agencies, and the development of joint assessments and interventions.

4.7.2 Progress against the recommendations

Nearly all the sites have implemented changes which address the organisational-level recommendations in the guide. This includes implementing inter-agency training to improve working, and establishing protocols which set out how children's and adults' services should work together.

These are very positive developments. However, it has not been possible within this evaluation to ascertain their impact on frontline practice or ultimately on service users. In particular, it would be useful to discover whether the protocols developed *do* help to prevent or resolve conflicts between agencies in terms of whose responsibility it is to

provide services, and whether this in turn improves the experience of parents and children. However, the evaluation undertaken in Southwark (Webber et al. 2011) suggests that the protocol has been helpful in clarifying roles and accountability.

4.7.3 New areas of practice

Again, the CAF process seems to be a useful vehicle for achieving many of the aims set out in the guide, provided the relevant agencies are committed to the process. For example, the process actively encourages the needs of both parents and children to be considered at assessment and when planning care. Similarly, TAF meetings provide a useful forum for adults' and children's staff to liaise and discuss the family in a holistic way.

4.7.4 Remaining challenges

One of the areas the sites have addressed to a lesser extent is the issue of the monitoring of adherence to protocols. In some sites, this was because the protocol was only finalised towards the end of the project – considering how to manage and monitor such protocols may now be a next step for several sites. In the future, the sites may wish to try and embed the protocol into other performance management so that managers can extract the data they need, or develop an audit tool.

4.8 Providing care

The guide emphasised gaps in current service provision regarding:

- services specifically aimed at the whole family
- existing services working with individuals, taking into account the family context of those individuals
- services providing social interventions to support practical problems, as well as therapeutic services.

4.8.1 What the sites did

One of the changes made to the provision of care was embedding specialist workers in another setting. For example, providing mental health support in family support settings, or providing family support via the CMHT.

Embedding support within other services

Liverpool and Southwark have introduced new posts to improve links between mental health services and children's centres. These use two slightly different models to achieve similar aims. In Liverpool, family support workers were attached to CMHTs. In Southwark, a team of senior adult mental health workers worked across the children's centres in the borough.

Both projects had similar intended outcomes, namely:

- improving early help and identification
- promoting good mental health among parents

- improving awareness and skills in relation to adult mental health within children's centres
- improving pathways of care between AMHS and children's services
- Increasing the numbers of parents with mental health problems who are registered with and make use of their local children's centre.

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

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

The project in Liverpool is approaching the end of its second year, and has produced an evaluation report of the first 20 months (Mersey Care NHS Trust 2012b). The workers have engaged with 187 families, supporting them to access mainstream children's services, including helping 119 families to register with children's centres. They have also supported children's centre staff to understand mental health issues.

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

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

4.8.2 Progress against the recommendations

It was difficult to distinguish progress on this compared to other recommendations. Some of the changes to screening and assessment described above will also affect service provision. For example, using the CAF should enable families to access non-statutory support services more effectively. Similarly, work done at a strategic level on joint working protocols should help to resolve some of the disputes about who provides certain types of service.

Few of the sites commissioned entirely new services during this project. This has partly been due to economic conditions during the project which led to many local services having their funding cut or withdrawn, and the fact that sites did not receive substantial funding to take part in the project.

The steering groups in the sites tended to emphasise getting existing services to work more effectively with families, and to work better together. This may be more sustainable in the long run: the approach of setting up new teams, as used in FIPs, was successful while it lasted (DfE 2011) but many of these projects were decommissioned when funding ceased. It should also be noted that, although not many *new* services were commissioned, sites had some successes in retaining funding for existing holistic family services. This highlights the progress that can be made within existing provision and with no or limited additional resources.

4.8.3 New areas of practice

It appears that the approach described above of embedding workers within other services has been a useful one. This has addressed several aspects of the guide recommendations:

- the family support workers attached to CMHTs have tended to provide social interventions, such as helping people get back to employment, rather than just therapeutic ones
- the mental health support provided in children's centres is available for people with less severe mental health problems, who may not meet the threshold for secondary services
- both projects are examples of creative ways of delivering services. Children's centres are a non-traditional setting for providing this kind of support, which may be less intimidating for families.

4.8.4 Remaining challenges

The original practice survey highlighted the lack of joint commissioning of services in relation to parents with mental health problems and their children. None of the sites have taken steps to address this specifically – as noted above, the period in which the project took place was often characterised more by the cutting of services rather than commissioning new ones. Linked to this, none of the sites have tackled the issue of involvement of parents and children in the commissioning process.

5 Implementing the guide: process

As well as exploring what changes to practice were effective in implementing the recommendations of the guide, this report also considered the *process* of change, and what factors helped and hindered change in the sites.

5.1 Approaches to implementation

5.1.1 Differences between the English and Northern Ireland sites

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

The Northern Ireland project has also had the capacity and mandate to engage in other strategic-level activities such as liaising with the regulator and providers of professional education, and meeting on an ongoing basis with government departments and non-departmental public bodies to share information and co-ordinate activities. SCIE has undertaken this role to some extent on behalf of the English sites, meeting regularly with the DH.

5.1.2 A multi-faceted, dynamic approach

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

Northern Ireland has, to some extent, followed this model and is working to a detailed regional plan. The sites there have also been able to develop several strategic documents which will have regional coverage, such as the knowledge and skills framework and the joint working agreement. However, at the English sites and, to a lesser extent the Northern Ireland sites too, the process of implementation has been more 'organic' than expected. The organic nature of the change manifests itself in two main ways.

'Lots of small changes can have a far reaching impact.'

Steering group member

Firstly, rather than sites implementing and rolling out a specific number of new, rigidly pre-planned activities, they have instead started to embed a think family approach in multiple existing documents and ways of working. This appears to be, in part, a response to the environment in which people are working. Most are implementing the

guide in addition to numerous other responsibilities. This leaves limited time for undertaking substantial stand-alone projects and means that the implementation work must be undertaken as part of other duties.

However, this was also an explicit strategy for achieving impact – the reality of working in local services is that for an initiative to be successful it needs to, and to be seen to, work in concert with other similar initiatives. Indeed, there are a priori reasons to think that multiply embedding think family in a number of policies and initiatives may help to ensure its longevity during a time of change: even if one policy or initiative is discontinued, others will continue.

The approach taken by the sites has also been organic in that they have responded to opportunities and changes in the practice and policy environment. For example, one site incorporated think family into a new structure for children's services. Others took the opportunity to include think family as part of general reform processes – for example, the reform implementation team and the Bamford task force in Northern Ireland. Others hope to exploit the constraints and restructuring affecting the sector to promote the early intervention and efficient working patterns inherent in whole family approaches.

'Think child, think parent, think family orientates you towards what we should be doing.'

Steering group member

While this has again meant that sites have not rigidly adhered to their plans, this appears to be beneficial in terms of using the changing policy environment as an opportunity rather than a threat.

5.1.3 'Quick wins' and a long-term strategy

The experience of the sites has shown that not all activities need to be large-scale or costly to have a positive impact. A number of sites have undertaken relatively quick and low-cost actions, which have helped to start the process of change. These include:

- lunchtime learning sessions
- ensuring that think family is included in staff inductions and safeguarding training
- liaison with key staff teams to ensure that practice is supporting a think family approach (e.g. that child in need risk screens are being completed).

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

5.1.4 Sharing learning and ideas

Working with a group of sites to implement the recommendations has proved beneficial. Several initiatives or practices developed in one site have been subsequently adopted in others, including cross-checking child protection investigations with mental health records, and practitioner champions groups. The sites have also shared ideas and learning on engaging with the full range of agencies, involving families and embedding

the work into other structures to ensure sustainability. Some healthy competition between the sites has also helped to keep up the momentum of change.

5.2 What are the barriers to, and enablers of, progress?

Throughout the implementation process, the sites have reflected on factors that have helped and hindered progress in their area. The following key factors have been identified.

'Of centrality to achieving progress is the collaboration across all partners ... Having senior representation and their ongoing commitment on the implementation group has been pivotal to this process.'

Monthly progress update from site

5.2.1 Competing pressures and organisational change

As noted above, most people involved in this project have also had numerous other responsibilities. Although they have found ways to manage this (including the 'organic' approach described above) it has been a challenge for those taking part to find time and space for the project amidst the many other demands they are subject to.

Unsurprisingly then, participants have reported that the competing priorities they face have been a barrier to making progress with this work. This is no reflection on their commitment or dedication, but rather of the large portfolio of responsibilities which is the reality of most professionals in health and social care.

In addition, a number of sites are experiencing organisational changes including restructuring of either local authority or NHS trust services or both, changes to senior management, staff reductions and proposed mergers of services. Again, although sites have done their best to make use of any opportunities presented by this, it has also had some negative impacts. The ongoing, and mounting, pressure of work meant that some sites began formally to drop aspects of their implementation plans, as it became clear progress would not be made. Some steering group members also had to leave the groups, either due to increased workload, or because they were moved to another part of the service.

5.2.2 Senior sign-up

One key factor that has come up repeatedly is the need for senior members of staff (e.g. assistant directors and directors) to sign up to this work. This is linked to a range of other factors including an impact on awareness of the project across the organisation, ensuring that links are made to other initiatives, the effectiveness of inter-agency working, and ensuring that staff are released for training.

These factors suggest that senior sign-up is important for:

- **leading** the work at a senior level
- **facilitating** relationships within and across organisations
- **allowing** other staff to make time for and prioritise this work.

This was shown to an even greater degree in the Northern Ireland sites, which secured endorsement from key regional stakeholders such as the chief executives of relevant agencies and policy-makers. This has enabled significant change to occur at a regional as well as a local level.

5.2.3 Changing working cultures

Steering group members have highlighted that, although progress has been made there still needs to be change to organisational cultures and people's conception of what falls within their remit.

There are also concerns that people may be even less willing to work outside what they see as their remit at a time of budget cuts and disinvestment.

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

'The obstacles are helping the staff group to feel comfortable working out of the "remit". Thinking about the family instead of just their individual service user, changing the culture of how we work.'

Steering group member

'Commitment from both CAMHS and AMHS has made [the think family] approach easy to explore. The group recognises that the pilot approach will enable lessons to be learned and the family care plan can be adjusted along the way.'

Site progress update

5.2.4 Time to build relationships

The extent to which true multi-agency working existed in the sites was unsurprisingly an important factor in determining progress. In sites with a history of working across agencies, key relationships were already in place, which helped people move forward. Elsewhere, it was clear that at least some members of project steering groups were meeting for the first time. This meant that in early meetings time was spent getting to know each other, learning about each other's roles and remits, and building relationships and trust. This is not unusual in multi-agency working. It did, however, reinforce the premise on which this work

is built: that AMHS and children's services do not always work closely together. It also highlighted the fact that even relatively senior members of staff (many steering group members are heads of service) in different agencies may not know each other.

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

5.2.5 Resources

Issues concerning money and resources have arisen at two levels: this project specifically, and the overall financial situation in the participating sites.

At the level of the project specifically, feedback from the sites has been mixed. Clearly, participation in the project did not come with significant additional funding, and sites have been aware of this from the beginning. The small amount of DH funding (£10,000) available to the English sites could not have a major impact, but has been put to good use including:

- project manager/administrator time
- e-bulletin development and circulation
- venue and refreshments for stakeholder events.

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

The broader financial climate has had an increasingly negative impact as the project has progressed. In Northern Ireland, efficiency savings in local services were thought to be likely to impede the project. Similarly, in the English sites, cuts to services were beginning to take effect by the end of the first year. This led to some relevant existing services having their funding cut or reduced, and also hampered sites' ability to fund new training and initiatives.

5.2.6 Administrative and project management support

Feedback from the steering groups suggests that having the support of an administrator and/or project manager is key to progress. Administrators have helped to provide practical support, such as taking and distributing minutes and agendas for meetings. However, they have also acted as 'lynchpins' for the steering groups, providing a single point of contact and continuity between meetings. In the sites which have project managers, this has also helped to drive progress and ensure that tasks were accomplished.

6 Conclusions and recommendations

Overall, this project has provided useful learning about how to implement the think family approach described in the SCIE (2009) guide *Think child, think parent, think family: a guide to parental mental health and child welfare*.

Progress against the recommendations

Looking across all the sites, good progress has been made against many of the recommendations in the guide. Sites have offered useful insights into how to implement the recommendations, in particular within the resource constraints which are now prevalent across services.

Between sites, there has been variation in the extent of progress, reflecting to some extent the different starting points of the various sites. Due to the cross-regional approach taken, the Northern Ireland sites have been able to make more comprehensive and far reaching changes, and liaise more with key strategic partners in government, higher education and regulation.

Increasing emphasis on early intervention and prevention

The majority of activities in the sites have focused on families who are known to either statutory children's social care services, community mental health services or both, or those who do not quite meet the thresholds for statutory or secondary services, but nevertheless are adversely affected by parental mental ill health.

Many sites devoted particular attention to those families who are below these thresholds, but nevertheless are struggling under the impact of parental mental health. Sites developed some innovative ways of supporting these families through use of the CAF and TAF, children's centres and other 'lower tier' or universal services, such as voluntary sector services and schools.

Working within existing services and resource constraints

In line with the recommendations of the guide, the sites have focused on improving existing services and the way they work together, rather than creating new structures or services. What's more, the English sites have demonstrated that substantial change can be achieved within existing resources, albeit requiring significant dedication, commitment and determination from those involved. Working within existing services and resources was not only practical, given the nature of the project, it also helped to secure the sustainability of the work in the future. The experience of the Northern Ireland sites, in turn, shows the significant benefits that can be achieved from more significant investment and cross-regional buy-in.

New areas of practice

In addition to valuable learning about how to implement the recommendations in the guide, sites have also tried out new areas of practice in keeping with the ethos of the guide, but not relating to a specific recommendation.

New areas of practice have included:

- the development of a knowledge and skills framework in Northern Ireland
- the use of a family experience survey to engage with service users and measure progress over time
- development of a set of standardised screening questions for use across a range of statutory and voluntary organisations
- embedding think family within existing training opportunities
- exploring the use of the CAF and pre-CAF as a means of identifying and addressing the needs of the whole family
- the creation of posts embedded within other teams.

Recommendations for future work

There were some key barriers that the sites continued to encounter which would benefit from further investigation. These included technical solutions to linking up children's services databases with mental health databases to facilitate both joint working on individual cases and extraction of population-level information on numbers and outcomes. This would benefit from exploration at a national level.

Linked to the above, there are still barriers to developing meaningful indicators that would help to measure progress in improving outcomes for families affected by parental mental ill health. The increasing emphasis on localism may mean that local sites and regions will have more flexibility to work on this in the future than previously.

This project included some promising exploration of the potential for the CAF in children's services to be used to support integrated working. There was less exploration of the possibilities offered by the CPA used in mental health services, which we feel would merit further investigation.

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

A note on terminology

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

7 References

- DfE (Department for Education) (2011) *Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011*, London: DfE.
- Davis, H., Day, C., and Bidmead, C. (2002) *Working in partnership with parents: The parent adviser model*, London: Harcourt Assessment.
- Easton, C., Morris, M. and Gee, G. (2010) *LARC2: integrated children's services and the CAF Process*, Slough: NFER.
- Evans C (1996) From those who know. The role of service users. In: C Hanvey and T Philpot (Eds) *Sweet Charity*. Oxford: Routledge.
- SCIE (2010) *At a glance 32: Think child, think parent, think family: a briefing for senior managers*, London: SCIE.
- SCIE (2011) *Report 44: Think child, think parent, think family: interim evaluation report*, London: SCIE
- Independent Inquiry Panel to the Western and Eastern Health and Social Services Board (2007) *Report of the Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards - Madeleine and Lauren O'Neill*, Western and Eastern Health and Social Services Board.
- Mersey Care NHS Trust (2011) *Family Rooms Review 2011*, Liverpool: Mersey Care NHS Trust.
- Mersey Care NHS Trust (2012a) *Family Rooms Review 2012 for secure mental health services*, Liverpool: Mersey Care NHS Trust.
- Mersey Care NHS Trust (2012b) *The Family Support Worker - Community Mental Health Teams and Children's Centres Project, Liverpool, April 2010-September 2011*. Liverpool: Mersey Care NHS Trust.
- Falkov, A. (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children - Reader for managers, practitioners and trainers*, Brighton: Pavilion Publishing.
- MRC. (2000) *A framework for development of evaluation and evaluation of RCTs for complex interventions to improve health*, London: Medical Research Council.
- MRC. (2008) *Developing and evaluating complex interventions: new guidance*, London: Medical Research Council.
- Needlman, R., Walders, N., Kelly, S., Higgins, J., Sofranko, K., & Drotar, D. (1999) 'Impact of screening for maternal depression in a pediatric clinic: an exploratory study', *Ambulatory Child Health*, **5**, pp. 61-71.
- Parker, G., Beresford, B., Clarke, S., Gridley, K., Pitman, R., Spiers, G., et al. (2009) *Research reviews on prevalence, detection and interventions in parental mental health and child welfare*, London: SCIE.

Patton, M. (1998) *How to use qualitative methods in evaluation*, California: Sage.

Pawson, R., and Tilley, N. (1997) *Realistic evaluation*, London: SAGE Publications.

SCIE. (2009) *Think child, think parent, think family: a guide to parental mental health and child welfare*, London: SCIE.

Shakespeare, J., Blake, F., Garcia, J., and Ciliska, D. (2004) 'Unacceptability of routine screening for postnatal depression was related to the screening process, the intrusiveness of questions, and the stigma of disease', *Evidence-Based Nursing*, **7**(2), pp. 61.

Stanley, N., and Cox, P. (2009) *Parental mental health and child welfare: reviews of policy and professional education*, London: SCIE.

Webber, M., McCree, C., and Angeli, P. (2011) 'Inter-agency joint protocols for safeguarding children in social care and adult mental-health agencies: a cross-sectional survey of practitioner experiences', *Child & Family Social Work*, pp.

WELB (Western Education and Library Board) (2008) *Understanding the needs of children in Northern Ireland (UNOCINI) guidance*, Omagh: WELB.

The mental health and wellbeing of children and adults in families where a parent has a mental health problem are closely linked. Not all families need health and social care services. However, those that do often struggle to get accessible and effective support that addresses children's needs and recognises the parental responsibilities of many adults with mental health problems.

In July 2009, the Social Care Institute for Excellence (SCIE) published a guide entitled *Think child, think parent, think family: a guide to parental mental health and child welfare* to help services improve their response to parents with mental health problems and their families. This document and its overall ethos are here referred to as 'think family'. This is the final evaluation report of the project, documenting the progress made by the sites involved, and making recommendations for future activity.

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