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

The Social Care Institute for Excellence (SCIE) supports the transformation of social care by identifying and transferring knowledge about good practice. We ensure that the experiences and expertise of people who use services, their carers and workers are reflected in all areas of our work.

Established in 2001, we are an independent charity funded by the Department of Health, Department for Children, Schools and Families, and the devolved administrations in Wales and Northern Ireland. We support care services for adults, children and families and we work collaboratively with partners at national and regional levels.

Think child, think parent, think family

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Contents

Introduction

This guide is about working with parents who have mental health problems and their children. It provides guidance on policy and practice and makes recommendations for key areas of professional education, workforce development and research. It also provides links to useful resources and contact details of relevant organisations.

Why have we written this guidance?

Parents with mental health problems and their children are a group with complex needs. Not all parents and children will need the support of health and social care services but those that do can find it difficult to get support that is acceptable, accessible and effective for the whole family.

This guide identifies what needs to change and makes recommendations to improve service planning and delivery, and ultimately to improve outcomes for these families.

Who is this guide for?

The guide has been written for staff in mental health and children's services from all sectors. It is also relevant for those delivering pre- and post-qualifying education and training to health and social care staff and others responsible for workforce development.

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

The Social Care Institute for Excellence (SCIE) will be producing additional resources, including training materials, to help embed the recommendations into everyday practice.

How was the guide developed?

This guide is based on a synthesis of the evidence from a number of reviews of the published literature in the last 20 years (1985–2005) and a practice survey (a review of existing practice in adult and children's health and social care services) carried out in five sites in England (2006–2008).

Full and summary reports of each review and the practice survey are available on the website.

A project advisory group of various stakeholders with a range of experience in the delivery or receipt of health and social care services for parents with mental health problems and their children advised on the development and content of this guide.

An external consultation took place during March/April 2009 and details can be found on the **website** from August 2009.

Your feedback

SCIE welcomes comments on any aspect of this guide, which will inform future updates. We are also interested in collecting examples of good practice. Please send us your **feedback**.

A note about terms used

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

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

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

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

Priority recommendations

The following recommendations are for adult mental health and children's services in all sectors.

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

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

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

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

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

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

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

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

Generating more evidence about what works
The recommendations in this guide emphasise the need to generate further evidence about 'what works for families' and this requires attention and resources to be dedicated to ensuring that the policy, service and practice recommendations in this guide are 'tried and tested' and their impact evaluated and reviewed.

Background

SCIE's unique responsibilities and independent status means we can help address cross-boundary and transition issues and tackle complexity in ways that other agencies are not able to do.

We have received regular enquiries and requests for information about working with parents with mental health problems and their children since our organisation formed in 2001.

In response we have produced a number of specific and related resources:

- **Working with families with alcohol, drug and mental health problems**
- **Families that have alcohol and mental health problems: a template for partnership working**
- **Promoting resilience in fostered children and young people**.
- **Support for disabled parents**.
- **A resource guide for children of prisoners**.

In 2004, SCIE in collaboration with partner agencies launched the Parental Mental Health and Child Welfare Network (this network is now run by the Social Perspectives Network, www.pmhcwn.org.uk). SCIE received an overwhelming response from people who have joined the network and come along to conferences and study days to debate this area of practice. Membership spans health and social care and adult and children's services. There are representatives from all regions in England, other countries in Europe and from as far afield as Australia.

In the early days of the network the focus of work was much more about awareness-raising in terms of the issues that parents and children faced in accessing acceptable and effective services. Very quickly, however, the top priority became the need for overarching guidance for policy and practice that considered the needs and wishes of parents, children and families and enabled staff to make the cultural and practice shift necessary to improve outcomes.

Based on the network's priorities, SCIE made contact with the Social Exclusion Unit, which agreed to include a recommendation in its publication *Mental health and social exclusion* (ODPM 2004) for SCIE to undertake a systematic review of existing practice and to publish new guidelines for health and social care staff in mental health and children and family services.

Undertaking the review of evidence was a complex and lengthy process. Several pieces of work were commissioned and SCIE undertook a survey of practice.

An advisory group of key stakeholders was recruited including parents and young people who contributed to the review and the development of the guidance.

We found lots of strong research evidence about the barriers to effective outcomes for parents with mental health problems and their children. But the evidence about what works to improve outcomes for these families was much harder to find.

Therefore, the synthesis and development of the guidance recommendations was not straightforward and an element of professional and family consensus was applied.

SCIE has addressed the need for more reliable evidence in a number of ways throughout the recommendation section of this document, the implementation and the evaluation plan, and will be integral to the review of this guide in three to four years time.

A wider programme of work

This guide is only one of four interrelated pieces of work that will provide knowledge-based recommendations for change and tools to assist the process of embedding these changes into practice as well as evaluating their impact. These four workstreams are:

- this strategic and practice guidance
- training and development resources
- six practice implementation sites which will share their experience of implementing the guidance and the outcomes achieved
- a national implementation and evaluation plan.

We realise that this guide is only the beginning and SCIE will continue our commitment by working hard with our partner agencies and families to implement and evaluate the recommendations in this guide over the next five years.

Structure of the guide

The next section describes the current policy and the organisation context, along with the expressed needs of parents with a mental health problem and their children.

We then describe the approach we have used to underpin the recommendations in this guide, which is to 'think child, think parent, think family', as this draws together the best of current practice alongside a renewed emphasis on thinking about families in all that we do. The Family Model (Falkov *et al.*) is then introduced as a useful conceptual tool to assist staff in thinking about different family members, their relationships with each other and the impact of external environmental factors. We conclude this section of the guide with a description of the characteristics of a successful service drawn from the requirements of law and policy, and messages from research and practice.

We then set out recommendations for what needs to change at every stage of the care pathway (see note on care pathway – page 20) and the implications for frontline staff, organisations and managers. We conclude that in order for this fundamental and systemic change to take place, changes are needed at every level for services to effectively meet the needs of families and such systemic and fundamental change requires a strategic approach in order to successfully influence and embed changes into mainstream everyday practice.

Finally, we describe how this guide fits with other areas of work and research that are being taken forward by SCIE with the aim of developing a knowledge base for good

practice in this area, and supporting staff and organisations to make the necessary changes and embed them into their mainstream work.

Current context

The background context to this guide is one in which:

- there is an evidenced-based rationale for the need for systemic change
- parents and children have articulated their needs and wishes
- current policy is urging services to 'think family' and to promote good mental health and wellbeing for all family members
- professionals have been open and honest about their concerns about managing and practising across the service divide
- the impact of practice and service development initiatives so far has been patchy
- there is a call from practitioners for more central leadership and guidance.

Evidence of the need for change

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

- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves (ODPM 2004).

- Of the 175,000 young carers identified in the 2001 census, 29 per cent – or just over 50,000 – are estimated to care for a family member with mental health problems (Dearden and Becker 2004).

- Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90 per cent of parents on their caseload have mental health problems, alcohol or substance misuse issues (ODPM 2004).

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

Between one in four and one in five adults will experience a mental illness during their lifetime. At the time of their illness, at least a quarter to a half of these will be parents. Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health. Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting impinge on adult mental health. Furthermore, the mental health of children is a strong predictor of their mental health in adulthood.

The views of parents with mental health problems and their children

The following is a synthesis of the findings from four separate studies that appeared in *Crossing Bridges* (1998) about what parents and children have said they want for themselves and each other (Aldrige and Becker 1993; Bilsborrow 1992; Hugman et al. 1993; NSPCC 1997).

In general, parents and children want appropriate understanding and support based on the different needs of individual family members. This support needs to be sustained over time, but should also vary to reflect any change in circumstances (Falkov 1998).

More specifically, for themselves, parents want:

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

For their children, parents want:

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

Children and young people want:

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

Children and young people taking on a caring role want:

- practical and domestic help recognition of their role in the family
- a contact person in the event of a crisis regarding a parent (Falkov 1998).

A group of young carers in Merseyside (Barnardo's 2007) came up with following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems:

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

The policy context

In recent years there has been a notable and welcome shift in children's and adult social care policy and guidance, which places greater emphasis on the need to support parents in their parenting role. The main policy drivers in England, Wales and Northern Ireland are as follows.

Every Child Matters: change for children

Every Child Matters: Change for Children (DfES 2003) sets out the national framework for local change programmes to build services around the needs of children and young people so that we maximise opportunity and minimise risk of poor outcomes. The Children Act 2004 (which also covers Wales) provides the legislative foundation for whole-system reform. It outlines new statutory duties and clarifies accountabilities for children's services. It acknowledges that legislation by itself is not enough: it needs to be part of a wider process that can only be delivered through local leaders working together in strong partnership with local communities.

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

1. Being healthy.
2. Staying safe.
3. Enjoying and achieving.
4. Making a positive contribution.
5. Achieving economic wellbeing.

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

Working Together 2006 addresses parental mental health and its impact on children.

Similar to Every Child Matters, in Northern Ireland 'Our Children and Young People – Our Pledge' (2006), is a ten-year strategy for children and young people, which seeks to achieve the following outcomes for all children and young people:

- Being healthy
- Enjoying, learning and achieving
- Living in safety and with stability
- Experience economic and environmental wellbeing
- Contributing positively to community and society
- Living in a society which respects their rights.

It identifies that not all children have an equal start in life and that targeted support should be available to particular groups to ensure that all young people have the opportunity to fulfill their potential. It proposes a 'whole child' approach to ensure support in each of these key areas.
(http://www.dhsspsni.gov.uk/child_care-carematters)

Mental Health and Social Exclusion report 2004

This report addressed the social and economic costs of mental health problems and their impact on family wellbeing and child development. Included in the report was a 27-point action plan to improve access to social participation, employment and services for those affected by mental health problems (SEU 2004). Action 16 of the plan focused on enhancing opportunities and outcomes for parents with mental health needs and their children. A review of the implementation of Action 16 can be found at http://www.barnardos.org.uk/action16-2.pdf

Families at risk review 2007–2008 and Reaching out: think family 2007

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

'The primary responsibility for a family's success or failure will always lie with parents, but government can make a significant difference to the chances of success. There should be no wrong door to help for families, so that whenever vulnerable parents turn to local services they receive support that recognises the needs of the whole family … If we're going to break the cycle of inter-generational exclusion, we must empower local services to always 'think family' and enable families to help themselves.'

Ed Milliband, Cabinet Minister responsible for social exclusion

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

- launching a series of **Family Pathfinders** to test and develop the 'think family' model and to generate and share evidence of what works on the ground

- continuing to invest in projects already shown to work including **Family Nurse Partnerships** and **Family Intervention Projects** (FIPs) with the aim of embedding early intervention and prevention within the existing system of support and extending tailored family services to reach a wider range of vulnerable families

- extending cooperation across children's services to include adult social services, so that all services share responsibility for family outcomes. The aim is to **encourage and empower frontline staff** to innovate and cooperate in response to whole family situations.

The Welsh updated *National service framework for mental health*, published in 2005, commits the Welsh Assembly Government and local authorities/local health boards to implement local and national action to promote social inclusion. Included within this is specific action to meet the needs of parents who have mental health problems. (Welsh Assembly Government (2005) *Raising the standard: The revised adult mental health national service framework and action plan for Wales*, Cardiff: Welsh Assembly Government).
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In Northern Ireland, the *Strategic framework for adult mental health services* recognises parenting roles in a section on carers and contains a recommendation that: 'Service users who are parents should be supported in their parenting role' (The Review of Mental Health and Learning Disability (Northern Ireland) (2005a) *A strategic framework for adult mental health services*)

Putting people first: a shared vision and commitment to the transformation of adult social care 2007

This landmark protocol (DH 2007) seeks to set out and support the government's commitment to independent living for all adults. Among the key elements of personalised adult social care are the following requirements:

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

Adult social care will also take responsibility for championing local action to tackle the stigma faced by people with mental health problems.
- **Putting people first: a shared vision and commitment to the transformation of adult social care**

Think child, think parent, think family

Refocusing the Care Programme Approach (CPA) 2008

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

- **Care Programme Approach (CPA) 2008 Briefing DH, SCIE, CSIP NW**

Parents with mental health problems and their children

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

New Horizons 2009]

New Horizons is a new strategy that will promote good mental health and wellbeing, while improving services for people who have mental health problems. It will build on the National Service Framework for mental health – widely acknowledged as the catalyst for a transformation in mental health care over the last 10 years – which comes to an end in 2009.

New Horizons heralds a dynamic new approach to whole population mental health. The focus on prevention and maintaining good mental health, and on promoting *recovery* is particularly relevant to parents with mental health problems and their children, as is putting mental health promotion at the centre of public health efforts. Many services are already in place, which aren't normally considered as mental health services, but which could help promote public mental health and wellbeing and prevent future problems across the lifespan and intergenerationally. It is these types of services that New Horizons could help to promote. Examples include:

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

The current organisational context

Research has shown that adult mental health and children's services need to work together to be able to meet the needs of families. However, the current organisational context is very complex. Mental health and children's services each have separate legal frameworks and therefore separate guidance on policy and practice. This has led to specialisation of knowledge and management structures within the different departments. Managers and practitioners have also reported that the lack of a family perspective in central policy directives has made it difficult to make progress in this area, at the same time as delivering other government objectives.

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

Service and practice developments

There have been a number of national and local developments in response to research evidence and consultation with people who use services. For example:

- **Crossing Bridges** –, a government sponsored 'training the trainers' programme (Mayes et al. 1998)
- the **Parental Mental Health and Child Welfare Network**, a national professional improvement programme – see practice examples
- **interagency service protocols and strategies**
- recruitment of specialist interface workers
- services commissioned specifically to offer **support to families** where there is a parent with a mental health problem.

Conclusion

The context for change is complex. This area of work cuts across a number of sectors and requires a multi-disciplinary response if outcomes for this group of children and families are to be improved.

Working in both adult mental health and children's social care services is particularly difficult. Both areas are highly emotive, they attract high levels of media attention and criticism, and staff can be wary of stepping outside professional boundaries. Breaking down these professional barriers is as important as addressing the stigma that exists in accessing services for parents and children.

Therefore our approach to developing the recommendations in this guide has been to consider not only what practitioners need to do differently but also what needs to be in place to support them in changing their practice – in particular what needs to be done at an organisational level to secure this change.

Think child, think parent, think family

The government's Think Family agenda recognises and promotes the importance of a whole family approach which is built on the principles of *Reaching out: think family* (SEU 2008b):

- **No wrong door** – contact with any service offers an open door into a system of joined-up support. This is based on more coordination between adult and children's services.

- **Looking at the whole family** – services working with both adults and children take into account family circumstances and responsibilities. For example, an alcohol treatment service combines treatment with parenting classes while supervised childcare is provided for the children.

- **Providing support tailored to need** – working with families to agree a package of support best suited to their particular situation.

- **Building on family strengths** – practitioners work in partnerships with families recognising and promoting resilience and helping them to build their capabilities. For example, *family group conferencing* is used to empower a family to negotiate their own solution to a problem.

- *Reaching out: think family*.

A family focus alone may not be enough to address the problems faced by some parents with a mental health problem nor will it necessarily prevent a child from suffering harm. The adults' problems need to be addressed through specific clinical expertise and services, just as children's problems need to be, or those requiring a whole family approach.

While the recommendations in this guide wholeheartedly support a family focus it should not be seen as an alternative to providing individual care, but must be considered alongside it. This means thinking about the child, the parent and the family, with adult and children's health and social care services working together to consider the needs of the individual in the context of their relationships and their environment. It should thus provide the optimum service that makes the best of what specialist training, knowledge and support is on offer. 'Think parent, think child, think family' is therefore the guiding principle for this guide.

The Family Model as a conceptual framework

The Crossing Bridges Family Model (Falkov 1998) is a useful conceptual framework that can help staff to consider the parent, the child and the family as a whole when assessing the needs of and planning care packages for families with a parent suffering from a mental health problem. The model illustrates how the mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked in at least **three** ways (see Figure 1):

- parental mental health problems can adversely affect the development, and in some cases the safety, of children

- growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood

- children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers.

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

Figure 1 The Family Model
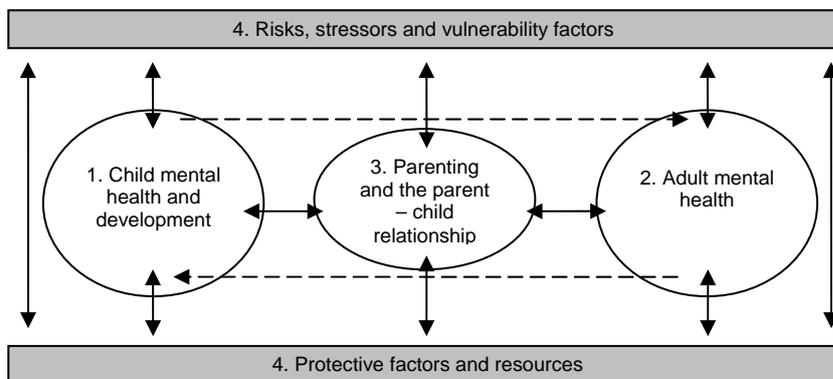
Risks, stressors and vulnerability factors

Individual risk or stress factors, on their own, do not necessarily have a serious effect on an adult's parenting capacity or their children's mental health. However, some parents with mental health problems will face multiple adversities. Risk factors are also cumulative – the presence of more than one increases the likelihood that the problems experienced and impact on the child and parent will be more serious.

It is when three or more environmental and/or personal factors occur in combination that a negative impact on child and/or parental mental health is much more likely. For example, the presence of drug or alcohol dependency and domestic violence in addition to mental health problems with little or no family or community support would indicate a increased likelihood of risk of harm to the child, and to parents' mental health and wellbeing.

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

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

Strengths, protective factors and resources

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

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

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

Risk to resilience

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

For children, all protective strategies operate through one or more of the following processes (**Bostock 2004**):

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

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

Promoting resilience does not mean minimising concerns about risk of poor outcomes. If a child is exposed to continuous and extreme stress, then they are very

unlikely to develop resilience. It is therefore unrealistic and unhelpful to rely exclusively on a resilience-led approach (Fraser et al. 1999).

Implications for organisations and for practice

An approach based on the Family Model enables staff to:

- know what to look for

- take a holistic approach to assessment and consider the environment, family, cultural and social systems within which individuals live (e.g. housing, finance, employment, relationships).

- gain a better understanding of the links and relationships between risk of poor outcomes and resilience, adult and child, symptoms and parenting, the changing pattern over time, and what to do with the information they gather

- understand the risks to health and wellbeing that occur across generations and manage these risks to reduce their impact.

Implications for the frontline practitioner

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

- switching from a focus on diagnosis or pathology to concentrate on individual strengths and interventions that are strongly associated with promoting mental health and recovery, sustaining families and promoting inclusion

- raising the expectations of people who use mental health services who are parents and taking seriously their views of their resource needs

- looking at the family as a unit and focusing on positive interdependency and supportive relationships

- helping parents to understand their mental health problems, their treatment plan, and the potential impacts of mental health problems on their parenting, the parent-child relationship and the child

- working with parents and children to enable the child to have age-appropriate understanding of what is happening to their parent and information about what services are available for them in their situation and how they can access these.

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

Characteristics of a successful service

The characteristics or indicators of success outlined below are drawn from the requirements of law and policy, along with messages from research and practice.

We have included this section as it gives an overview of what this guide is striving to achieve. It also provides broad outcome measures that can be used to assess impact locally and in evaluating the impact of the guidance overall.

A successful service will:

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

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

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

To achieve this, a cross-agency response will need to (Diggins 2009):

- draw upon an established knowledge base which integrates research evidence and practitioner and user expertise
- promote holistic assessment with a genuine focus on prevention and promoting the health and wellbeing of all family members

- include assessment and analysis of risk to health and wellbeing that investigates opportunities and obstacles for the present and the future

- ensure continued assessment of the impact of parental mental health on the family and if children are separated from their parents

- consider the timing and timeliness of interventions when prioritising services

- be flexible enough to deal with complexity and facilitate more cross-agency working for the benefit of parents and children

- strive to make services accessible, acceptable, effective and accountable to parents with mental health problems and their children.

Recommendations

The recommendations for change have been described in terms of what needs to happen at each stage of a generic care pathway, as changes need to take place at every step to ensure services are accessible and acceptable to families with a parent with a mental health problem. We have described the stages of the care pathway as:

1. Screening
2. Assessment
3. Planning care
4. Providing care
5. Reviewing care plans

At each stage, we first describe the problems with current practice. We then describe what a successful service would look like, and finally make recommendations as to what changes need to be made by practitioners, managers, organisations and at a national level in order to improve current practice and support staff to deliver a successful service.

A note about terms

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

Screening

Problems with current practice

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

- staff do not ask the right questions early on

- there are ambiguities with regard the to 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.

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In a successful service:

- all families are routinely screened to identify which adults with mental health problems are also parents in adult services, and which parents in children's services have mental health problems

- given a parent's permission, staff make contact with all other relevant agencies to assess, plan and deliver a coordinated care package for the whole family

- families with a parent with a mental health problem are routinely signposted or referred to other appropriate services

- staff develop supportive relationships with adults who use services to allay people's fears and reduce the stigma surrounding services.

Recommendations for change

Staff need to:

- Ask the right questions to identify families with a parent with a mental health problem. During the screening process, they should also explore the impact of any mental health problem on parenting and the child, and then put parents in touch with the right services. In children's services, staff will need effective ways of screening for and assessing parental mental health, including a tried and tested screening tool that identifies potential mental health problems. In adult services, staff will need to find out whether the adult is a parent or has childcare responsibilities and to record this. All staff may need training and support to understand why it is important to ask for this information and how to change their practice.

- Develop a working knowledge and confidence in how other services operate, what they have to offer and how to refer to them. Staff need to be able to reassure parents that services will meet their needs, provide written information about a service and, when necessary, be able to challenge other services and advocate on their behalf. This applies to staff in all settings. For example, **enabling children's centres, schools, FIPs** and GPs to navigate the local care pathway for mental health and children's services would provide a valuable mechanism to join up healthcare planning with family, parenting and children's services.

- Reassure parents that identifying a need for support is a way of *avoiding* rather than *precipitating* child protection measures.

- Involve parents and children as much as possible in the screening process, explaining that the process is important for making sure families get the support they need. This should be the start of developing a supportive and therapeutic relationship.

- Be proactive in developing good working relationships with their counterparts in other agencies, so as to facilitate joint working and shared case management.

Organisations need to:

- Develop new systems and tools in collaboration with parents and children (or customise existing ones) to routinely collect information about families where a parent has a mental health problem and record the data for future use. This information is essential for individual case assessment and care management. It is also crucial in building up a picture of the potential population for use by commissioners and managers of adult mental health and children's services.

- Provide training for their staff in talking with children, young people and adults to support the use of new screening tools as well as training to clarify roles and responsibilities in terms of collecting this information and acting on it. This applies to all staff in all agencies.

- Produce written and other formats of information about their services and include provision of translated materials and culturally sensitive information. This needs to include information about:

  ⇒ Adult mental health problems and the range of treatment and support available
  ⇒ the connections between adult mental health problems and parenting, and what has been helpful for families
  ⇒ how agencies work together to support individuals and families
  ⇒ services for young carers, as well as general information for all carers that explains what a carer's assessment is and what support is available
  ⇒ clear signposting to other services, including those providing parenting support and parenting education, and relationship support
  ⇒ local and national advocacy services.

- Develop a communications strategy to tackle the stigma and fears that parents and children have about approaching and receiving services. It should be a priority to enable families to get the support they need as soon as possible and the focus should be on promoting good mental health and wellbeing for all family members. This strategy needs to span universal, targeted/specialist and secondary services and reach families at all levels of need. It is best coordinated by Children's Trusts working with local commissioners of adult mental health services.

Managers need to:

- Develop a 'whole family' perspective and along with all other staff improve their knowledge and understanding of the interrelated nature of mental health difficulties, parenting and child development, and reflect this learning in decision-making.

- Provide advice and guidance, both informally and through more formal systems, to help frontline staff work across agencies and signpost and refer families to appropriate services.

Use management information systems/case management data and staff supervision and appraisal to ensure that referral, assessment and screening take place, that staff know how to use appropriate screening tools for adult mental health and are using them effectively. They also need to ensure that information-sharing is of high quality.

Assessment

Problems with current practice

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

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

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

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

- Different professional groups may not share the right information because they work to different criteria for information-sharing, use a different language and lack sufficient understanding of each others' roles. This means they may not understand what information is important for other agencies to have and so do not ask the right questions or pass the information on.

- Adult mental health staff are concerned that children's social care staff may make important decisions based on limited information such as a mental health diagnosis, or may over- or under react because they do not have a good understanding of mental health problems.

- Children's social care staff report that it is sometimes difficult to get reliable information from their adult mental health colleagues, particularly psychiatrists.

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

Think child, think parent, think family

- There are separate local criteria for adult and children's services which work against identifying the needs of the family as a whole.

- Criteria are set very high which can lead to some families falling through the service net.

- Local eligibility is based on weaknesses and problems. This means families must present themselves in ways which hide their strengths and resources and means they need to exaggerate their difficulties to get access to a service. This also makes it extremely difficult to identify and prioritise opportunities for early intervention and prevention.

In a successful service:

- The assessment takes account of the whole family's full range of needs – including those of young carers.

- The assessment takes account of present and future needs. For example, whether intervening in the present can help to avoid crises or prevent future ill-health for any member of the family.

- The assessment considers what support can be provided to maintain family wellbeing.

- Local eligibility criteria for services take account of the complex and varied needs of the whole family.

- Staff quickly identify the most vulnerable families, and intervene to prevent a crisis. All assessments comment on the mental health of both parents and any other adult member of the household, and record whether the parents live together and the degree of contact with children.

- All staff are equipped to identify cases where children are suffering, or are likely to suffer, significant harm and are able to respond quickly and effectively.

Recommendations for change

Staff need to:

- Take a systemic and socially inclusive approach to assessments. This is essential because parents often need advice on other matters such as housing and financial problems that would otherwise add stress and limit their chances of recovery.

- Involve all members of the family including the children in the process of assessment (as well as subsequent care planning and review). Staff may need to support children to be involved. They should also identify whether there is an adult or young person carrying out caring responsibilities in the family and where appropriate carry out a carer's assessment as soon as possible.

- Develop good working relationships with their counterparts in other agencies to support information-sharing and joint assessments. Staff need to gain a better understanding of other professionals' roles and their

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

- Be very clear about what information can be shared and with whom, also seeking parents' and children's permission for information-sharing wherever possible.

- Be able to recognise the most vulnerable groups and know from where to access appropriate advice, including: young mothers, women in the perinatal period, fathers, black and minority ethnic families, asylum seekers, parents with dual diagnosis or personality disorder, parents experiencing domestic violence, families who are separated and looked-after children.

- Be better informed about what forms of adult mental health problems and their symptoms and associated behaviours could present a risk of harm to children. Staff also need to be aware of their responsibilities for safeguarding children. (See Box 1).

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

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

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

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

- constantly vigilant

- open and inquisitive, regardless of any assumptions based on previous assessments

- aware of the need to reassess following new or increasing numbers of incidents and following changes in circumstances

- able to challenge colleagues within partner agencies if required

- aware of their responsibility to pass on concerns about the welfare of a child to Children's Social Care.

Think child, think parent, think family

Organisations need to:

- Adapt and develop existing assessment and recording processes to take account of the whole family. See **MHOAT practice example**.

- Provide staff with assessment tools (or amend existing tools) that identify the needs of parents, children, carers and young carers and take account of a family's strengths as well as their difficulties. These tools also need to be acceptable and accessible to families. They should be applied in universal, targeted and specialist, maternity and secondary care services. See **MHOAT practice example**

- Develop information-sharing and joint working policies/protocols to improve communication, coordination and collaboration within their organisation and across agencies.

- Train and support their staff in making joint assessments. Training should include how to interpret the information gathered in assessment and support should include clear signposting to specialist consultation and advice for complex cases (e.g. child and family mental health, risk assessment and culturally sensitive services).

- Develop and implement 'family' threshold criteria for access to services to take into account the individual *and* combined needs of parents, carers and children. They also need to ensure that vulnerable families meet necessary service thresholds, to ensure better access to services regardless of setting and agency.

- Train all their staff to increase their knowledge and understanding of adult mental health problems and their impact on the family in the present, over time and across generations, to help them identify when to intervene early or as a preventive measure.

- Train and support their staff to recognise the signs of adult mental distress so that they are aware of the risk of neglect, abuse and domestic abuse and are equipped to follow the local safeguarding procedures laid down for their services within their area.

Managers need to:

- Increase their knowledge of all parts of the professional network.

- Develop strong working relationships across divisions, particularly at senior management level.

- Foster a culture of respect for staff in different disciplines.

- Agree and record strategies for the management of joint cases (case files) where the situation is complex or there is a risk of poor outcomes.

- Develop new or adapt existing management information tools to ensure the quality and timeliness of assessments as part of their day-to-day supervision of staff

Planning care

Problems with current practice

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

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

In a successful service:

- Care planning takes a holistic approach to include appropriate care plans for each individual family member as well as the family as a whole.

- The care plan involves all members of the family in its development and implementation to ensure it is relevant, realistic and achievable.

- The care plan is flexible enough to meet the needs of the individuals and the family as a whole, and to be able to respond to changes in circumstances. Allocating an individual budget could provide this flexibility and give people who use services more choice.

- The care plan includes contingency and crisis preparation for both predictable and unforeseen situations. For example, a parent showing recognised signs and symptoms of becoming unwell, a parent being made redundant, or a young person needing stability at home to study for GCSEs. Respite care, agreeing who the child should contact if their parent becomes unwell and other support services can be planned for such events.

Recommendations for change

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

- The needs of the adult as a parent, and their child, are addressed separately and together.

Think child, think parent, think family

- The care plan explains the rationale for each recommendation including the preferences of the individual family members.

- The care plan includes realistic and relevant targets and timescales to address the specific difficulties faced by each family member.

- It is clear to all family members what the plan intends to achieve and how progress will be measured, including progress with parents' and children's understanding of the mental health problem.

- There is a clear explanation of what will happen, in what order and why, as well as who will be responsible for each intervention.

- There are clear lines of communication between staff providing services and individual family members.

- Parents and children/young carers can recognise when to ask for help and who to ask.

- There are clear arrangements for child care should the parent not be able to care for their children at any time. For example,during hospital admission. These should be agreeable to parents.

- It is clear how the views of family members will be obtained and recorded during the implementation of the care plan and its review.

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

- Parents will be assisted in understanding their own mental health problems

- Children will be helped to understand their parent's mental health difficulties

- Any potential negative impacts of mental health problems on the family will be minimised

- Children will protected from the risk of harm and supported to promote their continued development and wellbeing

- Communication will be improved between family members and relationships maintained

- Family health and wellbeing will be promoted and maintained.

Staff should consider whether using a 'personal budget' will give greater flexibility to the care package to better meet the needs of the individual and the family. See *Personalisation: a rough guide* (SCIE 2008)

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

Organisations need to:

- Provide training and support to their staff to improve the effectiveness and functioning of interagency working. This will support the development of coordinated care plans.

- Develop interagency policies/protocols in collaboration with parents and children that include a performance management and evaluation framework to ensure their use in everyday practice.

Managers need to:

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

Providing care

Problems with current practice

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

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

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

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

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

- the drivers for improving outcomes for these families are less significant in comparison with others

- there are no specific performance indicators to promote service provision in this area

- the existing **Quality and Outcomes Framework** standards for mental health are about assessing and treating individuals

- systems for joint commissioning across services exist, but are not yet being used fully.

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

- There is little long-term funding for services, even though families often experience chronic problems and would benefit from longer-term, 'revolving door' support. In many instances this might be less costly than, for example, hospital stays and children being looked after by the local authority. There would also be enormous value in enabling families to re-engage with services they trust.

- There are problems with funding joint care packages. Disagreements between services are often about who will pay for which service component.

In a successful service:

- Parents and children are meaningfully involved in developing, reviewing and evaluating services (e.g. commissioning processes and developing interagency service protocols).

- The specific needs of families with parental mental health problems are met.

- The variety of needs experienced by members of these families are addressed.

- Staff take a greater account of parents' priorities and desired outcomes and their perceptions about the cause of their mental distress. They are more sensitive to the sometimes complicated, chaotic lives some of these families lead.

- Support is provided in the long term through long-term funding for services that have demonstrated continuous positive improvements for families.

- Barriers to access are addressed, including practical barriers (e.g. transport and childcare), as well as acceptability factors (e.g. sensitivity to ethnicity, sensitivity to parents' other needs and priorities).

- The most vulnerable and excluded groups are targeted by services (e.g. young mothers, mothers in the perinatal period, black and minority ethnic families, asylum seeking and refugee families, staff who use services, parents with personality disorder or dual diagnosis and their children, families who are separated temporarily or permanently).

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

Recommendations for change

All staff need to implement interventions that will:

- address immediate concerns about the safety of children

- quickly identify and treat any mental health problems

- help parents with mental health problems to better manage their symptoms

- prevent crises and promote good health and wellbeing

- help manage a crisis quickly and effectively

- prioritise social inclusion

- reflect the priorities of parents and their families

- be flexible enough to take account of issues such as medication side-effects, scheduling of hospital appointments etc.

Organisations need to:

- Develop, implement and regularly review interagency protocols that include clear pathways for decision-making, that are explicit about who makes decisions and in what circumstances, so that decisions are timely and delays in allocating services are avoided.

- Involve parents and young people in the development, review and evaluation of interagency protocols.

- Develop or maintain services that meet the full spectrum of need in these families including:
  ⇒ services that tackle social exclusion issues
  ⇒ family-focused mental health services
  ⇒ services for families whose problems are less severe, but who need help to maintain their health and wellbeing (e.g. including access to psychological therapies – **IAPT**)
  ⇒ interventions that will reduce other stresses on parents (e.g. short breaks for parents and shared care options)
  ⇒ services for young carers
  ⇒ services that help parents with parenting (e.g. childcare, parenting skills courses)
  ⇒ services that support parents through crises (e.g. when a parent goes into hospital).

Think child, think parent, think family

- Develop commissioning processes to enable:

  ⇒ parents and children to be involved

  ⇒ joint commissioning across agencies

  ⇒ the development of non-traditional and creative ways of delivering services (e.g. delivering therapy services from libraries, community centres and children centres) as a means of targeting families and improving access

  ⇒ commissioning based on reliable information about how well services are meeting local needs

  ⇒ ongoing monitoring and evaluation to inform future planning and commissioning cycles.

- Change funding mechanisms to:

  ⇒ pool budgets so that adult mental health and children's services jointly fund these services, which will require developing new protocols that explicitly define who, how, why and when financial issues will be decided when agreeing multi-agency care packages

  ⇒ provide long-term funding (e.g. for voluntary sector services), so that they can continue to support families where a parent has a chronic mental health problem

  ⇒ make funds available for evaluating services, separate from the service delivery budget

  ⇒ facilitate the use of personal budgets to give more flexibility and choice for parents.

Reviewing care plans

Problems with current practice

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

In a successful service:

- Long-term assessments, involving continuous monitoring and review, enable services to respond to changes in family circumstances.

- Parents with mental health problems develop continuous, responsive relationships with trusted professionals, so that they and their children feel empowered to discuss any difficulties without feeling that they are being judged.

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

- Carers and young carers are involved in the care plan review for the person they care for.

Recommendations for change

Staff need to:

- Seek parents' permission and as far as possible involve children and young carers in the parent's care plan review process. This is important because young people can provide a valuable and unique perspective on what has been happening with their parent, how it is has been for them and what they think has worked well. They can then also comment on how any changes in the care plan might affect them.

- Aim to review the carer's plan as close as possible to the review of the adult's care plan. This will ensure the care plans work better together and reflect both individual and family goals. It will also ensure that any changes to the care plan that affect the carer are also addressed in their own care plan.

- Ensure care plan reviews consider change in family circumstances over time. For example, if important life events such as the birth of another child, a child studying for GCSEs, or the six-week summer holidays are coming up, then this needs to be explored and any contingency or extra support included in the plans if necessary.

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

- Ensure that the care plans for the parent and child are reviewed when a parent is hospitalised or receiving respite and again before they are discharged.

- Prioritise and address any financial and housing issues arising from hospitalisation (e.g. interruptions in welfare benefits, assistance with child care to avoid a parent or carer having to take unpaid leave to look after the children during this time).

- Contact or help parents to contact their children's school to make them aware of the temporary changes in the family to maintain family life during a time of crisis and ease the path of return when the parent returns home.

- On discharge from hospital or during periods of 'hospital leave' ensure that enough time is given to put any identified support in place for the parent and child as 'coming back together' for families can be a very stressful time with high expectations.

- If children and families or other essential support services are involved in the parent and children's care then it is imperative that the doctor and ward staff in charge of the parent's inpatient care involve named agencies in discharging planning or give adequate notice of discharge arrangements. See *Parents in hospital* (Barnardos 2007).

A strategic approach

Based on this review, changes are needed at every level for services to effectively meet the needs of families with a parent with a mental health problem. Such systemic and fundamental change requires the following strategic approach in order to successfully influence mainstream practice:

1. A multi-agency-led review and development of services.

2. Senior-level commitment to a strategic review and implementation of new policy and practice.

3. Training and development of the workforce.

These will be discussed in turn.

A multi-agency-led review

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

- Mapping the services currently available across all sectors to parents with mental health problems and their children, and identifying how well the services meet these families' needs across the full spectrum of problems.

- Working in partnership with parents and children at all levels and at all stages to ensure a service user centred approach to developing and delivering services that reflects what families say they want. Involving parents and children will lead to better service outcomes.

- Generating clear family-focused outcome measures, management targets, accountability measures and agreed audit and evaluation plans to monitor and evaluate the implementation of the strategy.

Children's Trusts and local commissioners of adult mental health services are well placed to initiate, manage, monitor and report on the development and implementation of a strategy. They will need to take the lead in coordinating and managing change.

Senior level commitment

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

Specific organisation or management targets are also necessary for these changes to become a priority for mainstream practice. Embedding the changes in culture and practice requires strong leadership and high-quality management. Managers and supervisors have a responsibility to ensure that the changes happen in practice by:

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

We therefore recommend that:

- a 'think family strategy' is developed for leaders and managers, to engage them in taking forward the recommendations for change

- local 'champions' are identified with specific responsibility for ensuring that recommendations are implemented

- training managers are charged with delivering the training programmes necessary to support all staff – frontline practitioners and senior-level managers.

Workforce development

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

We therefore recommend that in terms of professional qualifications:

- those responsible for professional education and training and workforce standards should introduce a family perspective.

In terms of continuing professional development we recommend that:

- For social workers (adult and child), accredited post-qualifying standards and courses should include specific material about how to deal with complexity, think child, think parent and think family, and how to work across service interfaces to promote the social inclusion and health and wellbeing of individuals and families. This is best delivered after a year or more in practice.

- Joint training is provided for staff in adult mental health and children's services or for other professional groups (e.g. primary and secondary care staff), as this can help to break down barriers and increases people's understanding of other service areas and responsibilities.

Think child, think parent, think family

- A new leadership programme for adult and children's social work supervisors and managers should be developed. This should help managers to support staff who are working across agencies and dealing with complex cases.

Research recommendations

Service and practice evaluation

SCIE's *Parental Mental Health and Child Welfare Training Resources* (under development – available in 2010) will include material to assist staff and organisations to undertake good quality evaluations of their services.

The following research questions were identified for further research in the SCIE commissioned reviews and practice survey:

- Are the experiences and needs of fathers with mental health problems different? The literature is dominated by research on mothers or undefined 'parents', who are usually mothers. See *Research reviews on prevalence, detection and interventions in parental mental health and child welfare: summary report* (SCIE 2009)

- Are the experiences and needs of parents with mental health problems from black and minority ethnic communities different from those of parents with mental health problems in majority communities and, if so, how best can they be identified and supported?

- Are the experiences and needs of 'looked-after children' who have birth parents with mental health problems different to children living with parents with mental health problems, and if so how best can they be identified and supported?

Future developments

Web and e-learning training and development resources

A set of online SCIE training and development resources explicitly linked to the recommendations in this guide will be developed and published in 2010.

These resources will test and develop your knowledge in relation to parents with mental health problems and their children, and provide ideas and models for service and practice development based on the recommendations in this guide. The resources will include materials and guidance for trainers.

SCIE guidance implementation sites

There are six implementation sites in England and Northern Ireland which have agreed to work collaboratively with SCIE to record and evaluate the processes and outcomes of putting the policy and practice recommendations in this guide into practice and to share the outcomes of this work with others.

Details of the implementation plans and their progress for the five sites will be posted on the SCIE website late in 2009.

Supporting implementation and evaluating outcomes

The recommendations in this guide emphasise the need to generate further evidence about 'what works for families' and this requires attention and resources to be dedicated to ensuring that the policy, service and practice recommendations suggested here are 'tried and tested' and their impact evaluated and reviewed.

SCIE will lead a national implementation and evaluation plan in collaboration with partner agencies using the key messages and recommendations in this guide for future evaluation and review. The linked training resources and implementation sites will provide important resources for achieving these goals. Further information about the components of this plan and progress made will be posted in this section of the website from September 2009 onwards.

Resources

Whilst this is not an exhaustive list of the wide range of resources that are available on parental mental health and child welfare, it is a starting point for accessing information that supports and informs the guidance. The vast majority of the references are hyperlinked, designed to give instant access as you need it.

Advance directives

- Royal College of Physicians (2009) ***Advance care planning: national guidelines.***
- Social Care Institute for Excellence (2009) *Mental Capacity Act 2005 resources.*
- MIND (2008) *Overview and key provisions of the Mental Capacity Act 2005.*
- MIND (2008) *Healthcare and welfare/Personal care decisions under the Mental Capacity Act 2005*.

Carers and young carers

- Social Care Institute for Excellence (2007) *Implementing the Carers (Equal Opportunities) Act 2004,*
- Butler, A. and Astbury, G. (2005) 'The caring child: an evaluative case study of the Cornwall Young Carers project', *Children and Society*, 19(4), September 2005, pp 292–303.
- Becker, S. and Dearden, C. (2004/05) 'Carers', Research Matters, No18, October 2004–April 2005, pp 11–18.
- Fox, A. (2004), 'Who cares about us?: the unmet needs of young carers' Childright, No 209, September 2004, pp 17–18.
- Princess Royal Trust for Carers (2002), *Consultation with carers: good practice guide*.
- Office for Standards in Education, Children's Services and Skills (OFSTED) (2009) *Supporting young carers: identifying, assessing and meeting the needs of young carers and their families*, Manchester: OFSTED.
- Becker, F. and Becker, S. (2008) *Young adult carers in the UK: experiences, needs and services for carers aged 16–24*, Woodford Green: Princess Royal Trust for Carers.
- Department of Health (2008) *Carers at the heart of 21st-century families and communities*, **London: Department of Health**.
- Aldridge, J. (2008) 'All work and no play?: Understanding the needs of children with caring responsibilities, *Children and Society*, 22(4), July 2008, pp 253–264.
- Bernardo's (2009) Barnardo's 10 messages from young carers (part of '*Keeping the family in mind*' project and pack), Ilford: Bernardo's.

- Bernardo's (2009) *For children's sake* (anti-stigma pack), Ilford: Barnardo's.
- Rethink (2001) *Young carers of people with a severe mental illness*
- Children's Society (2008) Young Carers Initiative, ***Promoting good practice for young carers and their families***
- Princess Royal Trust for Carers (2008) Young Carers.net – information and advice for young carers.

Children and families policy and guidance

- Every Child Matters
- Department for Children, Schools and Families (2008) *Parenting Implementation Project.*
- Department for Children, Schools and Families (2009) *Safeguarding children.*
- Department for Children, Schools and Families (2008) *Family Pathfinders project*.
- Department for Children, Schools and Families (2008) *Family Intervention Project.*
- Social Care Institute for Excellence (2008) *Factors that assist early identification of children in need in integrated or inter-agency settings.*
- Social Care Institute for Excellence (2008) *Children of prisoners.*

Children's and families' services

- Barnardo's – information and support for young carers
- Childline – free 24-hour telephone counselling service
- Family Action – providing practical, emotional and financial support to families through over 100 services based in communities across England.

Confidentiality and information sharing

- Royal College of Psychiatrists (2004) *Carers and confidentiality in mental health.*
- Department of Health (2005) *Confidentiality and Disclosure of Information: General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS) Code of Practice 2005.*
- Patient Information Advisory Group

Developing interagency protocols

- Social Care Institute for Excellence (2006) *Supporting disabled parents and parents with additional support needs*
- Social Care Institute for Excellence (2007) *Working together to support disabled parents*.
- Social Care Institute for Excellence (2003) *Families that have alcohol and mental health problems: a template for partnership working*

Think child, think parent, think family

Family visiting rooms

- Robinson, B. and Scott, S. (2007) *How mental health services can best promote family contact when a parent is in hospital*, Ilford: Barnardo's.

Mental health services

- MIND – offering support and information about mental health
- NHS Direct – 24 hour advice from trained nurses
- The Princess Royal Trust for Carers – provides comprehensive carers support services across the UK.
- Rethink
- Sane – information and advice for people with mental health problems and those who support them.
- Samaritans – confidential support for people needing emotional support.
- Young Minds – information about mental health for young people.

Parent and children's accounts

- Social Care Institute for Excellence (2008) *Experiences of children and young people caring for a parent with a mental health problem.*
- Social Care Institute for Excellence (2008) *Children's and young people's experiences of domestic violence involving adults in a parenting role.*
- Bernardo's (2009) *Keeping the family in mind – resource pack.*
- Townsend, M. (2007) *The father I had*, London: Bantam Press.
- Cowling, V. (ed) (2004) *Children of parents with mental illness*, West Drayton: Acer Press.

Personalisation and user involvement in service change

- Social Care Institute for Excellence (2008) *Seldom heard – Developing inclusive participation in social care.*
- Social Care Institute for Excellence (2008) *Looking out from the middle: User involvement in health and social care in Northern Ireland.*
- Social Care Institute for Excellence (2007) *Developing social care – service users driving culture change.*
- Social Care Institute for Excellence (2007) *Improving social and health care services.*
- Social Care Institute for Excellence (2008) *Personalisation: a rough guide.*
- Social Care Institute for Excellence (2009) *Co-production: an emerging evidence base for adult social care transformation.*
- Social Care Institute for Excellence (2009) *Changing social care: an inclusive approach.*

Mental health policy and practice guidance

- Department of Health (2009) *New Horizons Next Steps For Mental Health Policy*

- Department of Health (1999) *National service framework for mental health: modern standards and service models*.
- Care Quality Commission – inspection for health and social care.
- Department of Health (2002) *Women's mental health: into the mainstream.*
- Department of Health (2008) *Refocusing the care programme approach: policy and positive practice guidance*.
- Department of Health (2008) *Making the CPA work for you: booklet and summary leaflet.*
- SCIE/CSIP/DH (2008) Care programme approach (CPA) Briefing: Parents with mental health problems and their children
- Department of Health (2009) Mental Health Act 1983 information leaflets.
- Independent mental health advocates
- Department of Health (2009) *Valuing people – a new strategy for learning disability for the 21st century.*

Professional development and improvement networks

- Parental Mental Health and Child Welfare Network
- Children of Parents with a Mental Illness (COPMI) – Australia

Recovery model

- Social Care Institute for Excellence (2008) *Supporting people in accessing meaningful work: Recovery approaches in community-based adult mental health services.*
- Social Care Institute for Excellence (2007) *The recovery approach in community-based vocational and training adult mental health day services.*
- Social Care Institute for Excellence (2007) *A common purpose: Recovery in future mental health services.*

Resilience and stressors

- Social Care Institute for Excellence (2004) *Promoting resilience in fostered children and young people.*
- Social Care Institute for Excellence (2008) *Stress and resilience factors in parents with mental health problems and their children.*
- Social Care Institute for Excellence (2005) *Managing risks and minimising mistakes in services to children and families.*
- Social Care Institute for Excellence (2008) *Learning together to safeguard children: developing a multi-agency systems approach for case reviews.*

Screening, assessment tools and guidelines

- Gopfert, M. (ed) (2004) *Parental psychiatric disorder: distressed parents and their families*, Cambridge: Cambridge University Press.

- Falkov, A. (ed) (2008) 'A family-focused assessment tool' in *The Clinician* MH-Kids Volume 4, Vulnerable families: children of parents with mental illness.
- Mental Health outcomes and training tool (MHOAT)
- DCSF and University of Warwick (2008) *Health-led parenting interventions in pregnancy and early years*.
- Mental Health Foundation (2003) *From pregnancy to early childhood: early interventions to enhance the mental health of children and families*.
- National Institute for Health and Clinical Excellence (2007) *Antenatal and postnatal mental health: The NICE guideline on clinical management and service guidance*.
- Royal College of Psychiatry (2007) A series of resources on postnatal depression
- Royal College of Psychiatry (2007) *Being seen and heard (Patients as parents) training pack*.

Social inclusion
- Social Exclusion Taskforce (2009) *Families at risk review*.
- Social Exclusion Taskforce (2009) *Family nurse partnerships*.
- National Social Inclusion Programme (2009) *Vision and progress: social inclusion and mental health*.
- Social Exclusion Unit – ODPM (2OO4) *Mental health and social exclusion*.
- Social Care Institute for Excellence (2008) *Black and minority ethnic parents with mental health problems and their children*.
- Social Care Institute for Excellence (2009) *The relationship between dual diagnosis: substance misuse and dealing with mental health issues.*
- Barnardo's (2008) *Family minded: supporting children in families affected by mental illness*.
- Barnardo's (2009) *Improving opportunities and outcomes for parents with mental health needs and their children: A review of the implementation of Action 16 of the Mental Health and Social Exclusion Action Plan 2005– 2008*.

Training and development resources
- Meriden project
- State Government, Victoria, Australia (2007) *Families where a parent has a mental illness: a service development strategy*.
- Department of Health (1998) Crossing Bridges training resources for working with mentally ill parents and their children reader – for managers, practitioners and trainers.
- Barnardo's (2009) *Keeping the family in mind.*
- Social Care Institute for Excellence (2008) *Poverty, parenting and social exclusion*.

Practice examples

Meriden Family Programme

What is the idea?

The Meriden Family Programme is a training and organisational development programme promoting the development of family-sensitive mental health services. The overall aim of the programme is to:

- train clinical staff, voluntary organisation staff, people who use services, carers and others in the skills needed to work with families experiencing mental health difficulties
- ensure that workers are able to implement these interventions following receipt of training, through influencing management and creating a supportive host culture in their organisation.

More details can be found at **www.meridenfamilyprogramme.com**

Why is this a good idea?

There is an existing evidence base across cultures, including Japan, India and New Zealand suggesting that the provision of Behavioural Family Therapy results in the reduction of relapse rates and reliance on mental health services. The focus on the involvement of family members has been shown to have positive outcomes for them.

Who are the stakeholders?

Originally funded from 1998 to 2004 through central West Midlands regional funding, Meriden worked closely with all the mental health provider trusts within the West Midlands. Several of these trusts provided funding for 2004 to 2007. From April 2007 onwards, the funding has come from a range of sources including West Midlands Mental Health and Primary Care NHS Trusts and through other organisations, primarily NHS and social care. It now sits as an NHS programme, hosted within Birmingham and Solihull Mental Health Foundation NHS Trust, with a regional remit. Meriden also operates at a national and international level.

Stakeholders include purchasing organisations, management links, clinical staff, people who use services and carers/family members together with a number of statutory and voluntary sector organisations.

Why do/did the stakeholders think it was a good idea?

A Meriden evaluation showed that stakeholders felt strongly about the service provision for families and saw the need for this innovative approach. Meriden felt that implementing evidence-based practice improved clinical practice and services for families. Further, the approach enabled staff to include the family, rather than focusing on the individual.

The programme was established in 1998 and it has been difficult to locate material indicating the degree to which people who use services and their carers were part of the initial development of the programme. However, it is clear that their contribution has always been central to the development and delivery of the training materials. Since 2008, the Programme has employed a carer consultant as an integral member of the core team.

What are/were the desired outcomes?

The desired outcome was to train clinical staff, people who use services and carers in the specific skills needed to work with families experiencing mental health difficulties. These skills included the sharing of information (including psychosocial education and relapse prevention strategies), problem solving and communication skills.

What was/will be done to achieve them?

Process: Meriden worked closely with all the mental health provider trusts within the West Midlands region to provide a comprehensive programme of training and implementation..

Practice: The intervention involves training professionals, who later train others to work with families (cascade method). The model of family work is based on assessment of the whole family, followed by a skills-based intervention which includes the sharing of information (psychosocial education), skills in detecting early warning signs and relapse prevention, improved communication skills and a six-step problem-solving technique. Staff are closely monitored and supervised to ensure a consistent approach and adherence to the model.

What did stakeholders think about methods?

Through Meriden's own evaluation processes, stakeholders reported that this evidence-based method influenced the implementation of family work within their trust and provided greater awareness of family issues. They also thought it helped establish and maintain family work as one of their trust's core functions. Further, they thought the method would help facilitate compliance with guidelines and policies.

More specifically, the programme's commitment to family work, support they provide, special interest groups (e.g. parental mental health), and international reputation, helped to make the approach accessible and encouraged them to drive family-sensitive services forward.

What have the outcomes been (both intended and unintended)?
In total, Behavioural Family Therapy (BFT) training has been provided to over 3,600 psychologists, nurses, psychiatrists and other staff. Over 210 trainers have also been trained. In addition to courses held in the West Midlands, and due to the absence worldwide of any similar programmes, invitations to train

teams have been received from across the UK. As a result, Meriden has delivered training in the north and south of England, London, Ireland, several areas in Scotland – travelling as far afield as Singapore and Australia.

People who use services and carers have been actively involved in a number of capacities. Several have trained as therapists and some of these have trained as trainers. They act as consultants to the programme and play an active role in special interest groups. In addition, a carer consultant is employed as part of the core Meriden team.

It would appear that as a result of action in the area of training staff to deliver the BFT model with families experiencing mental health difficulties, the programme has become involved with an increasing range of issues including:
- the development of family work in in-patient and acute services, and crisis/home treatment teams
- family interventions within early intervention in psychosis services
- reaching hard-to-reach groups e.g. ensuring family work is accessible to culturally diverse groups; work with assertive outreach teams; work in forensic settings
- family interventions within older adult services
- child and adolescent mental health services (CAMHS) and the needs of children whose parents experience mental health difficulties.
- links with higher education and curriculum development
- greater involvement of people who use services and carers both in training and delivery of family work
- carer education and support, (the Meriden Caring for Carers programme), with specific adaptations for use with black and minority ethnic (BME) carers and also substance misuse and alcohol services.

This suggests that an unintended outcome of greater expertise in one area is the uncovering of issues, and hence the need to address, issues in another.

The contribution made by the programme has been recognised by the professional stakeholders in a number of ways. Meriden was joint-winner of the National Institute for Mental Health in England (NIMHE) 2003 Positive Practice Award for Modernising Mental Health Services and winner of the Social Care Award (Midlands and East Region) in the Health and Social Care Awards by the Department of Health in 2005. In 2008, the programme won the Health Service Journal (HSJ) award for Mental Health Innovation.

Dr Gráinne Fadden, Meriden's Programme Director, states the most obvious benefits are for people who use services and carers who report feeling much more involved in the care process, feeling listened to by professionals and feeling more in control should their family member experience a relapse. A number of carer stories can be found on the Meriden website.

Think child, think parent, think family

A small-scale study of 10 families who received the intervention, carried out in 2004[1] suggests that families were very satisfied with the intervention. They reported reductions in the levels of stress within the family, reduction in levels of carer burden, enhanced communication skills and a positive sense of empowerment, attributable to receiving BFT. The majority of families viewed mental health professionals and services more favourably compared to their experiences before receiving BFT.

The approach is aimed at empowering families to resolve difficulties themselves and so reduce professional interventions and statutory responses. While there is likely to be a consensus amongst stakeholders that reducing the relapse rates was desirable the question of increasing compliance with medication is more problematic. It would be interesting to see feedback from people who services feedback on this issue. One user was cited on Psychminded.co.uk in relation to BFT, as stating: 'It's comforting to see everyone in the family getting on so much better. Everybody made the effort to live with me, and it gave me the inspiration to carry on.'

Feasibility

Meriden clearly demonstrates that it is possible to cascade a training initiative and maintain control over the quality of both training and practice delivery.

Affordability

The programme represents value for money given its scale. From the planning in August 1997 to March 2004, the programme cost £350,000. This was possible as the strength of the leadership of the programme is to inspire and motivate others, and to develop partnerships. This shows what can be achieved at low cost through getting the existing workforce to work differently rather than by employing additional staff. The cost of the programme for 2004 to 2007 was £260,000 per year (total £780,000), and for 2007–2008 was £496,000. The total cost of the programme has been £1.6 million averaging out at £162,000 per year.

The Being Seen and Heard training pack

What is the idea?

To improve the practice of the range of professionals working with families experiencing parental mental health problems by producing training and video materials aimed at ensuring the needs of children are addressed.

Why is this a good idea?

The authors suggest that the investment in time, effort and resources to improve the practice of professionals is justified because there is a wealth of evidence suggesting:
- a substantial proportion of people who use mental health services are parents
- parenting with mental illness is especially challenging
- children in families experiencing mental health issues are at greater risk of a range of mental health problems and adverse life experiences
- improving the mental health and wellbeing of people who use mental health services who are parents is very important for the individual, and brings great benefits for their children.

Who are the stakeholders?

- Camden and Islington Mental Health and Social Care Trust
- Camden and Islington Family Service Unit
- Camden Area Child Protection Committee
- Royal College of Psychiatrists
- London Mental Health Learning Partnership
- Professionals working with people who use mental health services, other users and their families

Do/did the stakeholders think it was a good idea?

The professionals involved in the development of the project were committed to its completion and dissemination. As this is a long established project there is no information recording the views of the stakeholders at the point the idea was being developed. Parents and children were involved in its production but it is not clear how far they were involved in the steering group overseeing the development of these materials.

What are/were the desired outcomes?

The stated aims of the video and accompanying training materials were to:
- ensure the needs of children are addressed
- enhance effective multi-agency working.

Think child, think parent, think family

What was/will be done to achieve them?

The DVD contains video clips of parents with mental health problems and their children, clearly signposting key issues for use as part of single or multi-agency training courses.

The materials emphasise the need to:
- enquire about and address the parenting role of the person using the services
- ensure that the child is listened to and provided with information about a parent's condition.

What have been the outcomes – intended and unintended?

Professionals using the materials have commented:

'Extremely informative...as a training video it is excellent, managing to give young carers a voice.'
Young People Now

'Content is well organised and edited. ...A useful training tool across professional groups and cultures.'
Child and Adolescent Mental Health

'Extremely useful for mixed groups of children's social workers and mental health workers.'
ADSS Inform

'Wow! What a wonderful film! ...this is a must. This film makes the point forcefully that the welfare of children is everyone's business.
Mental Health Practice

'A film that is already being talked about. We have heard of seasoned managers dabbing their eyes and teachers provoked to anger.'
Child and Adolescent Mental Health

Comments from people who use services are not readily available but the 'think family' message expounded in the training materials clearly resonates with the views of families expressed in the practice survey.

Feasibility

The DVD and associated materials are widely used as a training resource as evidenced by the practice survey. The notion of gaining the consent and active participation of people who use services and their families in the provision of training was innovative and clearly continues to have resonance today. It is a method of involving people who use services and raising professional awareness that could be adopted by other groups to illustrate and address other issues.

Affordability

Full information on the cost of production is not available. However, the cost of purchasing the materials is £35.25 (incl. VAT).

Think child, think parent, think family

Children and Parents Empowered (CAPE) project, Greenwich

What is the idea?

The CAPE project aims to provide direct support to Greenwich families experiencing severe and/or enduring parental mental health problems and change practitioner attitudes to ensure services reflect family needs.

Why is this a good idea?

The project focuses on the family as a whole, encouraging positive attachments and resilience, strengthening family relationships and promoting social inclusion by raising awareness among professionals of the impact of parental mental illness and working to improve joint working between agencies. The aims are securely based on widely accepted evidence that parental mental health can adversely affect child development and that parenting can impact on mental health.

Who are the stakeholders?

Greenwich Social Services and Oxleas NHS Foundation Trust secured funding from the Gatsby Charitable Foundation to develop and implement an innovative project to address the needs of children and families in Greenwich who were affected by parental mental health problems.

Do/did the stakeholders think it was a good idea?

As this is a well established project it is difficult to access materials describing the stakeholders' responses as the project evolved.

What are/were the desired outcomes?

Improving communication and joint working between the agencies as evidenced by;
- reducing the number of 'crises' referrals to children and families and adult mental health services
- reducing the number of emergency/unplanned placements of children
- reducing the number of emergency/unplanned hospital admissions of adult parents/carers
- providing services which meet the needs of the whole community and increase confidence in, and take-up of services by users from black and minority ethnic communities and other disadvantaged groups in the borough.

What was/will be done to achieve them?

Process: Following a needs analysis by the National Children's Bureau, which found that parents with mental health difficulties and their children represented a significant need group, Greenwich Social Services and Oxleas NHS Foundation Trust secured funding from the Gatsby Charitable Foundation for a project to address these issues. Funding was provided for:

- establishing a multi-disciplinary team to ensure a holistic view of family needs
- training across a wide range of disciplines in Greenwich and beyond, to raise awareness and knowledge
- consultancy and outreach services to offer support to both families and practitioners
- establishing links between adult mental health and children's services
- introducing new protocols and procedures, backed up by appropriate training
- initiating and developing a multi-disciplinary perinatal clinic (TIME clinic) to support pregnant women who use mental health services and women identified as being at risk of postnatal mental illness.

Practice: Support is offered to families through direct work and by providing training and consultation to practitioners working either with adults with mental health problems and/or with children.

Work includes:
- planning with families for periods of hospitalisation
- arranging hospital visits for children
- supporting expectant and new mothers likely to experience mental health difficulties
- supporting families to get children to school
- accessing activities for children
- understanding the impact of mental illness on them – parenting skills
- care planning with families for crisis.

What did stakeholders think about methods?

An evaluation by NCB[2], employing a range of research methods including the analysis of monitoring data and feedback from staff, families and key stakeholders from relevant services concluded the CAPE Project has successfully developed a range of services to support practitioners from adult mental health and children's services, all of which have been well received.

What have been the outcomes – intended and unintended?

The project aimed to change hearts and minds of key practitioners to enable a greater awareness of the impact of parental mental health on the whole family.

The evaluation document suggests the project brought about significant change which was acceptable to both people who use services and practitioners. It has helped agencies comply with their statutory requirement to know whether patients are parents, and whether they are in contact with their children:

- The multi-disciplinary composition of the team ensured a holistic service to families and facilitated communication and liaison between agencies.
- Links between adult mental health and children's services were reported to have been enhanced.
- The development of new protocols and procedures led to a greater awareness of families' needs and hence better informed and more appropriate referrals.
- Stakeholders report that the TIME clinic fills an important gap between adult mental health and children's services.
- Adult services have had fields relating to parental status added to their databases and CAPE Project staff has worked to ensure that these fields are used in practice.
- Joint working between agencies is more commonplace.
- Impact on children of parental mental health is more routinely assessed.
- There is increased confidence in imparting information with regards to parental mental health to children
- The data gathered in the evaluation does not enable a full assessment of the impact of the CAPE Project on individual service users. However, case studies provided examples of reported impact, including reduced anxiety, increased confidence in parenting skills and increased trust in services.

In part the projects success can be seen to be linked to its independent, multi-disciplinary nature enabling the making of links with key sections of both CSC and AMH to bring about changes but its very independence raises issues of funding. In order to maintain the project staff time and energy have to be diverted to managing this issue.

Feasibility

The project since its inception in April 2005 has provided advice and consultation on over 250 new cases, with 700 follow-up contacts and so is clearly feasible. The process is well documented and indicates the project's ability to adapt to local need.

Affordability

The project's continued success depends on securing on-going funding. Specific details of costs were not available.

Mersey Care Family Room Project

What is the idea?

To improve the experience for children and families when visiting a relative receiving in-patient care by working to set up a 'family visiting room' in their local psychiatric hospital.

Why is this a good idea?

Young Carers Liverpool had articulated some of the difficulties they faced in finding private, supportive and child appropriate spaces to visit parents receiving in-patient treatment. This resonated with the experience of other young people, people who use services and professionals striving to maintain family links during hospitalisation and was recognised more widely within the research community[3]

Who are the stakeholders?

- Mersey Care NHS Trust
- Barnardo's Keeping the Family in Mind.

Do/did the stakeholders think it was a good idea?

The original idea was generated and developed by young carers within Barnardo's Keeping the Family in Mind project.

What are/were the desired outcomes?

The initial aim was to develop one family-focused visiting room in a local hospital. One commissioner commented:
'Children would have a long escorted walk along endless stark corridors.… the intensive care unit is also on the ground floor, where children could see very disturbed patients being admitted.'[4]

What was/will be done to achieve them?

Process: Barnardo's Action With Young Carers was established in 1991. Through the involvement of children and young people who access the Barnardo's North West Action with Young Carers projects, Keeping the Family In Mind (KFIM) was established as an independent development project in 2001.
The project supports young people to make their voices heard and has been involved in a range of developments, echoing the needs of young carers, A number of factors have contributed to the success of this unique project, such as the fact that it was initiated from the 'bottom-up' – driven by the children of people who use services in Liverpool, and embraced by staff at ward level. It

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was initiated as part of a wider plan to support all Merseyside mental health service users who are parents – a factor that has supported its sustainability. The project has been championed and mainstreamed by managers and staff at all levels of the organisation.

Practice: Mersey Care Trust acted on the concerns and ideas of the KFIM group to provide and furnish 11 family visiting rooms throughout the trust.

What did stakeholders think about methods?

Detailed information on the process is not available but there is clear anecdotal information that the stakeholders were in agreement about the methods used.

What have been the outcomes of this work – intended and unintended?

The issue of a family room was used to promote more family-focused services and impact on professional practice in in-patient services. As a result, staff more readily recognise the importance of patients' parenting role and are beginning to undertake pro-active work with families.

An evaluation of the Mersey Care family room provided evidence that the provision of this facility encouraged staff to talk to patients about family issues, and focused attention on the needs of families. A young person commented:
 'I could ring up at anytime if I was worried about Mum. I rang up everyday when I was away on holiday and that was brilliant.'

Feasibility

This initiative could be replicated in other trusts but is more likely to succeed where there is commitment at both ward and management level, informed by the views of people who use services, including those of young carers. Such initiatives need to become part of mainstream practice in order that responsibility is taken for their upkeep. The additional benefits in terms of the continued promotion of family-focused services will be more likely where there has been an agency review of practice in line with policy, undertaken in collaboration with other stakeholders, (user groups and children's services, in particular) to develop a strategic approach to supporting all people who use mental health services who are parents, their carers and their children.

Affordability

Information on the cost of developing family rooms is not readily available but anecdotal information suggests significant improvements can be achieved for minimal outlay; most services have a re-decoration budget.

The Family-Focused Assessment (FFA)

What is the idea?

To provide a tool for use by mental health clinicians to support systematic clinical assessment and recording of the needs of children whose parents are referred to or known to a mental health service where concerns about parenting and children's needs including safety are identified.

Why is this a good idea?

All family members are affected by parental mental health problems. Available evidence indicates that despite parental fears, most children are not removed from their parents' care, the majority of parents want the best for their children and the majority of children want their opinions sought and to be kept informed. Timely discussion and systematic appraisal of need can help to minimise the impact of parental mental health problems on children, parenting and general quality of family life.

Who are the stakeholders?

The FFA was developed by Dr Adrian Falkov and MH-Kids in conjunction with InforMH, the information unit of the New South Wales Department of Health (Mental Health and Drug and Alcohol Office) Australia.

The main beneficiaries of the tool are intended to be the children of parents experiencing mental health difficulties, their parents and the clinicians providing services.

Do/did the stakeholders think it was a good idea?

Feedback was generally positive throughout the piloting process, acknowledging the importance of this tool to support practice and emphasising its role to support, not replace, the clinical process.

What are/were the desired outcomes?

- To ensure that adult mental health staff record details of parents who use services
- To provide a framework for gathering, collating and analysing information relevant to the needs of parents with mental illness and their children in a structured format
- To ensure the needs and views of children of people who use services were recorded
- To assist clinicians in the prioritisation of need, to identify particular gaps in service provision and to inform risk management

Think child, think parent, think family

What was/will be done to achieve them?

Process: The tool was piloted initially by the Copmi coordinators (children of parents with mental illness) and others directly involved with children whose parents experience mental health problems.

Subsequent drafts were piloted as part of the field testing for the review of mental health clinical documentation in New South Wales, prior to endorsement and availability for all services in New South Wales.

FFA has been formally endorsed and included within the suite of revised mental health clinical documentation. It is intended for use in all mental health services in New South Wales.
Further evaluation will be required to ascertain uptake and usage as well as impact on practice and outcomes for families.

State-wide rollout of training (Crossing Bridges New South Wales) which includes use of the FFA is planned to commence in 2009.

Practice: Adult mental health practitioners will discuss parenting needs with people who use services as well as their children's needs as part of the assessment process and collect and record information about:
▪ current parent functioning and impact of symptoms on parenting
▪ child's current functioning
▪ concerns expressed by others about child's safety
▪ strengths, vulnerabilities and risk factors

All of this information is used to inform the clinical management plan and judge the need to refer any child of the family to other services, including safeguarding.

What did stakeholders think about methods?

While the FFA provides an important opportunity to address staff anxieties associated with children's needs in adult mental health services and parental mental health needs in children's services via use of tools, frameworks, training and protocols and evaluation. Concerns have been expressed from a few mental health services regarding need for associated training for staff, whether the FFA is sufficiently balanced regarding strengths as well as weaknesses and underlying anxiety amongst adult mental health staff about skills, competence and role delineation.

These issues indicate the need for an implementation plan, training (using adapted Crossing Bridges) and evaluation.

What have been the outcomes of this work – intended and unintended?

- The evidence suggests an improvement in a range of areas including systematic assessment.
- Care planning which incorporates parenting needs

- Children's wellbeing and safety.

Feasibility

Developing and implementing an assessment model of this kind within adult services would require close collaboration with partner agencies and some joint training. In many instances this model could build on existing inter-agency structures.

Affordability

There was no financial information available. However, the main costs are for staff development time, and the time needed to pilot and systematically evaluate a clinical tool.

Family Action Building Bridges projects

What is the idea?

Based on the Building Bridges[5] materials these projects aim to bridge the gap that often exists between adult mental health and children's services. This is done through providing a direct flexible and holistic service to meet the needs of families where parents have profound and enduring mental health problems. The service is available outside normal office hours and is tailored to meet families' needs.

Why is this a good idea?

The Building Bridges projects were developed in response to growing recognition, concern and evidence about the number of families affected by parental mental health difficulties, its impact on family life and their interrelated needs. Although these issues are beginning to be addressed by adult mental health and children's services, there is an argument that the voluntary sector is well placed to provide the holistic and flexible response required to engage and support families experiencing mental health difficulties.

Who are the stakeholders?

- Family Action
- Social Services
- NHS mental health trusts locally.

Do/did the stakeholders think it was a good idea?

Although these projects preceded the implementation of this evaluation framework there is considerable research evidence that families experiencing mental health difficulties wanted a flexible service, available outside working hours that was responsive to individual need[6].Similarly staff working with adults and those working with children variously recognised the need for a more holistic approach to families.

What are/were the desired outcomes?

To provide a service which would:
- improve family relationships by improving parents' and children's understanding of one another's needs
- support parents to access other agencies
- improve communication between the various agencies involved with families
- be task-centred and time-limited.
- be available when other services are not, i.e. key 'family times'

- use internationally validated clinical tools to measure the effects of service intervention[7].

What was/ will be done to achieve them?

Process: Family Action has used the Building Bridges model to provide family support services since 1999 with the first project in the London Borough of Lewisham. There are now 12 projects across England. The model is also used by services supporting parents with learning disabilities and other complex needs.

Practice: Families refer themselves or are referred by professionals. The service is led by a qualified person, and utilises unqualified family support workers who go into families' homes to help with practical issues and provide emotional support, when it is needed.
- The families' perceptions of their needs and the issues they want to address are key to the work undertaken.
- A flexible and holistic service, available outside normal office hours is offered, tailored to meet families' needs.

What did stakeholders think about methods?

These projects were developed prior to the implementation of the SCIE framework and, as such, materials documenting the responses of stakeholders are not readily available. However, the fact that each project, although adhering to a service delivery model informed by the Building Bridges materials, has developed in response to local need, suggests that the stakeholders were able to influence the development of their local project. An evaluation report of the Building Bridges projects confirmed that Family Action Building Bridges projects also use the practical, flexible and partnership approach which research indicates is valued by parents.

What have been the outcomes of this work – intended and unintended?

The evaluation produced positive feedback from other agencies and from parents themselves. Partner agencies valued the projects for their ability to work with families where there are high levels of needs, their positive working relationships with professionals, and the flexible and practical support provided to families particularly when there were significant concerns about children's welfare.

Parents thought that Building Bridges helped prevent deterioration in family relationships, helped their children to understand about mental illness and assisted in their relationships with other agencies. A statistically significant improvement with parents' satisfaction with their family relationships and with their parenting over the time that Building Bridges projects were involved with families was found. This improvement in both remained at the six-month

follow up but was not statistically significant on the measurement of satisfaction with family relationships.

For children, there was a statistically significant improvement in levels of depression amongst children aged 11 and under. The tool adopted for children aged over 11 measured levels of self-esteem and, while levels of self-esteem improved on average this was not statistically significant. The project is unusual in attempting to measure, in a robust way, the impact of their interventions. The difficulties in such evaluations are well documented (Ibid).. The number of questionnaires completed at six months after closure of a case remains relatively small and firm conclusions about whether or not service interventions have any lasting effect should probably not be drawn until there are more questionnaires to analyse.

Feasibility

The outcomes evidence clearly indicates the services provided by Building Bridges are wanted by people who use services and their children. The independent evaluation suggests a statistically significant improvement in parents' satisfaction with their family relationships and with their parenting, when assessed six months after the period of intervention but further work is recommended to assess longer term impacts.

Affordability

Information exists regarding the cost of each of the projects which is accessible via FWA, but as each project is tailored to local need this can only serve as a guideline given costings will depend on the exact nature of the project and existing resources.

Family Health Isis

What is the idea?

Family Health Isis is a voluntary sector project committed to promoting the rights of African and Caribbean people with mental health challenges by providing a range of culturally specific services to meet their needs.

Why is it a good idea?

The project development was based on a variety of research findings which show that African and Caribbean people using mental health services continue to be misdiagnosed, overmedicated, and subject to higher rates of control and restraint than their white counterparts. This is despite having similar rates of mental ill health as any other ethnic group.

Who are the stakeholders?

Family Health Isis was founded in June 1986 by a group of mental health professionals, people who use services and community workers, and was initially launched as The Black Mental Health Group. Funding has since been secured from a variety of sources including the London Borough of Lewisham and South London and Maudsley Mental Health Trust (SLaM).

Do/did the stakeholders think it was a good idea?

Although it is difficult to locate details of the project's inception, such records as do exist suggest the project grew out of the commitment and determination of local professionals and people who use services.

What are/were the desired outcomes?

The initial stakeholders were committed to providing a staffed centre and to raise the profile of the needs of the African and Caribbean people with mental health problems, along with their carers, family and friends, in order to work towards greater choice and flexibility in service provision to the African and Caribbean community.

What was/ will be done to achieve them? (Describe process)

Process: The Black Mental Health Group had many diverse aims. Information detailing the process by which they have achieved these aims is not available. It is clear however that by encouraging discussion and exploration of mental health issues within the African and Caribbean community, they have been able to facilitate a positive contribution by the African and Caribbean community to mental health service planning and delivery. There is evidence of their ability to work collaboratively with statutory and independent agencies to create greater choice and flexibility in terms of service provision to the African and Caribbean community.

Think child, think parent, think family

Practice: Isis' services include:
- individual support to both relatives and friends of people with mental health problems and to people experiencing mental distress
- group activities include keep fit, the women's group, the men's group, as well as music, sewing, arts and crafts and creative writing workshops. There is also a long established social gathering group.

In addition the project provides:
- advocacy; a flexible and client-focused support service
- carer and family liaison offering practical support to families experiencing mental health difficulties
- advice and information including benefits and rights in relation to housing, employment, the Mental Health Act and general information about race and mental health issues
- training and awareness – providing practice placements for students undertaking social and community work training.
- assertive outreach team – acting as an interface between members and other agencies in a culturally sensitive way
- in-reach support – facilitating hospital admission for those requiring it and providing support to in-patients to lessen trauma and disruption
- counselling – enabling people to be self-motivated and self-confident.

What did stakeholders think about methods?

Again it is difficult to evidence the stakeholders' responses to processes described above. It is however clear from information within the practice survey and on the web site that it is a service valued both by funders and people who use services. Users at Isis praised the service, and were especially complementary about Isis' advocacy role, its counselling service, and the fact it would help people with whatever problems they had. One user stated: 'I don't think I'd be as happy now if there wasn't an Isis.'[8]

What have been the outcomes – intended and unintended?

Review evidence is not available but as the oldest established black mental health organisation it is of interest to note that the project is now involved in a diverse range of activities, such as providing student placements and was recently a pilot site for a diabetes education programme. Isis, now a well respected local resource, has a long history of partnership working with NHS mental health services in Lewisham who work together to provide joint assertive outreach services.

The partnership approach between Isis and NHS services is beneficial for both organisations. Isis fills gaps in NHS services, and acts as a valuable, critical friend to NHS services, and in return much of Isis funding comes from the NHS. Isis staff is involved in the induction process for new NHS mental

health staff, and have also been involved in the recruitment process for NHS staff. All of which suggests that Isis is well respected in a variety of settings.

Feasibility

Anecdotal evidence suggests that at its inception the aims of the Isis Family Health project were relatively modest but due to the commitment of the staff and people who use services involved, they have been able to identify and respond to local need and so meet their original aspiration to create greater choice and flexibility in terms of service provision to the African and Caribbean community. As such, there is no reason a similar service could not be replicated elsewhere.

Affordability

Financial information is not available.

Think child, think parent, think family

Keeping the Family in Mind project and resource pack

The Keeping the Family in Mind project (KFIM) is a strategic, rather than an operational piece of work, which been responsible for, or involved in, a range of inter-related projects, all of which are intended to improve services for families with children affected by adult mental ill health. This results in services being more accessible, non-stigmatising and timely. The work includes young carers and those children and young people who may become carers if adult services do not 'think family' and support parents adequately.

What is the idea?

To harness the ideas and energies of young carers and those who work with them to change service provision to recognise that parental mental ill health affects the whole family, initially by developing a resource pack for sale to practitioners.

Why is it a good idea?

The project and its various products, including the resource pack, are built on the premise that young carers, an untapped resource, are affected by parental mental ill health. They are often best placed to identify both their own needs and those of their mentally ill parents but all too often these needs are overlooked as the focus of the professionals is either 'adult needs' or child's needs' rather than 'family needs'.

Who are the stakeholders?

The main stakeholders are Barnardo's Action with Young Carers, and the involvement of children and young people who access the Barnardo's North West Action with Young Carers project. They established KFIM as an independent development project in 2001.

Additionally, the stakeholders for the resource pack include any family affected by parental mental illness and the professionals working with them.

Do/did the stakeholders think it was a good idea?

All the materials described below were written and produced with the participation of children and young people themselves.

'We have got lots to say: the challenge is to really listen to us and only then can we all work together to make things better for us and our families.' - (Young Carers, Barnardo's Action with Young Carers Liverpool)

What are/were the desired outcomes?

- To raise awareness amongst practitioners of the issues faced by families affected by parental mental illness.

What was/will be done to achieve them?

Process: Young carers accessing Barnardo's North West Action with Young Carers project were supported to make a DVD 'Telling it like it is', which conveys the key issues faced by young people affected by parental mental illness. This was supplemented with postcards and posters, reports, booklets and advice sheets, which make up the resource pack.

The initial production of 500 copies sold so well that CSIP agreed to help produce a new, improved second edition.

Practice: Work to maintain a focus on the impact on the whole family of parental mental ill health continues and has sparked a range of connected activities described below.

What did stakeholders think about methods?

The quotes below indicate a positive response from a wide range of stakeholders:

'The training materials are brilliant, they inspire, motivate and offer hope …I know that it is being widely used by people in child and adolescent services.'
(Mike Shooter, Former President of the Royal College of Psychiatrists)

'I imagine all universities providing social work training would be interested in the pack as it provides a child's perspective which can often not be provided directly in training.'
(Nora McClelland, University teacher (social work))

'I think the great strength and selling point is the family focus and approach.'
(Jo Tunnard, Independent trainer, Research in Practice)

What have been the outcomes – intended and unintended?

Having raised awareness of the issues both locally and nationally , the KFIM project has gone on to tackle other issues of concern to young carers and their families and has been involved in bringing about the following changes:
- Family Visiting Rooms in Hospital project.
- the Jelly Baby kite marking logo, to indicate family-orientated mental health services
- the Postcard, anti-stigma campaign to raise awareness of the impact on children of the stigma of mental health difficulties
- The 10 Messages campaign, which aims to challenge the way professionals relate to young carers
- The Message in a Bottle pack, which addresses the issues of importance to families who may experience emergency hospital admission.

Think child, think parent, think family

The Annual Report 2007/08 gives details of the specific numbers affected by individual initiatives and cites positive responses from young carers, their families and partner agencies to the work achieved.

Feasibility

The KFIM project has been able to achieve the above outcomes by systematically identifying local need and the desired change, utilising local resources to meet the need, engaging people who use services and professionals along the way. This process has recently become more formalised as the Liverpool FAMILY Collaborative, which grew of the SCIE-commissioned Liverpool Practice Survey and the Keeping the Family in Mind movement.

The Collaborative utilises a quality improvement methodology which instead of making a change throughout the entire system that requires years of planning for implementation, changes are made quickly in very small increments, utilising Plan-Do-Study-Act (PDSA) Cycles.

Affordability

The KFIM resource pack was designed to cover costs. It currently retails for £34.99.

Parental Mental Health and Child Welfare Network

What is the idea?

To develop a network of professionals and users of services to share and disseminate best practice in the field of parental mental health and child welfare.

Why is this a good idea?

Research and enquiry reports have established the links between parental mental illness and child welfare issues, highlighting the need for mental health and children and family services to work together to meet the needs of families. The network aims to raise practice standards by improving knowledge, sharing information and influencing policy change.

Who are the stakeholders?

Practitioners in AMH, CAMHS, CSC and users of services

Do/did the stakeholders feel it was a good idea?

The views of the above were canvassed at a study day hosted by SCIE. Individuals were invited to register, which suggests stakeholders shared the view it was a positive initiative.

What are/were the desired outcomes?

To develop closer working relationships between mental health services and children and family services in order to better meet the needs of families experiencing mental health difficulties.

What was/will be done to achieve them? (Describe process)

There has been no formal recent review of the Network as yet. Feedback from study days and from survey information (May 2007) indicate high levels of member satisfaction with the Network, which is regularly used to re-shape and develop activities. A further survey of the membership is planned.

A report reviewing progress on Action 16 [7] indicated that the network was one of a number of significant national developments promoting collaboration between different organisations.

The Network's success in fulfilling its aims was summed up by the Director of the Social Perspectives Network suggested ''The study day was a reaffirmation of the Network's ability to draw together service users, practitioners and researchers with a shared objective of improving the quality of services. '

Think child, think parent, think family

Feasibility

This is a successful national resource which clearly works in practice. The plans to develop regional networks demonstrate its applicability elsewhere.

Work is underway, following DCSF agreement to provide advice and small start-up finance to encourage existing groups and support new groups.

Affordability

The Network has been successfully developed and run, funded by a three-year grant from DCSF totalling £30,000 over three years and aims to be self-financing by the end of the period. Additional income has been generated from twice-yearly study days.

Safeguarding Leads project

What is the idea?

To establish a national network for named and lead professionals for safeguarding children in mental health trusts in England. The network aims to develop and influence best practice in relation to the needs of parents experiencing mental health difficulties and their children.

Why is this a good idea?

The safeguarding role in mental health trusts is relatively new and practice is still emerging. Leadership and the ability to influence best practice were felt to be crucial. Post holders felt that the lead safeguarding role in adult mental health is very different from that of named or designated nurses in a primary care trust and that the majority of existing best practice guidance related to the latter role, hence the need to clarify their role.

Who are the stakeholders?

The named and lead professionals for safeguarding children in mental health trusts in England.

Do/did the stakeholders think it was a good idea?

Participants have found the network very helpful. Many work in isolation and benefit a great deal from other professional experiences in both sharing examples of best practice and in being a source of professional support.

What are/were the desired outcomes?

To share best practice in relation to families experiencing parental mental illness and to build capacity within safeguarding systems by means of sharing, debating and working towards the implementation of regionally and nationally agreed examples of best practice in the area of parental mental health and child welfare.

The safeguarding leads priority actions for 2008/09 include:
- dissemination of findings from scoping exercise
- dissemination and refinement of positive practice guide and resource pack
- joint work with stakeholders to influence the Common Assessment Framework
- comment on the Personality Disorder guidelines and other emerging policy
- support for the development of regional groups for safeguarding and mental health
- contribution to the development of a national standard of good practice
- organisation of a national learning event.

Think child, think parent, think family

What was/ will be done to achieve them?

Process: Following Lord Laming's enquiry into the death of Victoria Climbié it became a requirement for adult mental health services to have a named nurse for child protection. The Safeguarding Leads project was developed in December 2007 to help and support the process of establishing this role and clarifying its remit.

In response to the above a national steering group (of the Safeguarding Leads) grew out of the Action 16 Group.(ibid). It sought to devise and develop structures to establish a national network.

In May 2009 arrangements for running the network changed. Previously it had been run jointly by SCIE and CSIP, hosted by SCIE. However, it now lies with the Department of Health.

It is seeking further funding to develop its work and is actively committed to representation from people who uses services on the network steering group.

Practice: The current focus is on developing the structures to support a network by which to share issues of common concern and to disseminate best practice, by means of regional meetings. Its business plan summarises the work achieved so far. It includes amongst its successes the dissemination of:
- the Derbyshire Protocol for Safeguarding Children in Mental Health Practice
- Child Needs and Risk Assessment Aid
- Practice Guidance for Mental Health Practitioners.

What did stakeholders think about methods?

The key stakeholders are the named nurses for child protection within adult mental health services, their staff and partner agencies and ultimately the families they provide services to. To date, there has been no formal means of capturing the views of people who use services, though the project is committed to their involvement.

What have been the outcomes for this work – intended and unintended?

Whilst there has been no independent evaluation to date it is possible to say they have achieved their initial aim of raising awareness of the family model in relation to parental mental health and child welfare issues and are currently seeking funding to embed and enhance the work of the project.
However some people have argued that developing more formal links with safeguarding leads within local authorities would more effectively ensure the development of the 'Family Model' at a strategic level with partner agencies.

Feasibility

The Safeguarding Leads network is currently operational and serves as a possible example for other interest groups wishing to develop a similar support framework for practitioners.

Affordability

Further funding is being sought from the Department of Health. At present, SCIE helps to host some e-knowledge community/networking arrangements. However projects of this nature need to secure continued funding in order to ensure that the work involved in maintaining a network is adequately supported and does not become burdensome to those energetic and committed individuals, responsible for its continuation.

Think child, think parent, think family

The Parkside Parental Mental Health Service: 'Still Waiting for an Answer'

What is the idea?

To involve a voluntary sector specialist child care agency to ensure that the needs of children living with parental mental health issues, were addressed, in conjunction with the needs of the adult who uses services.

Why is this a good idea?

In recognition of the inter-relatedness of parental mental ill health, parenting and child development on all family members and the traditional difficulties in co-ordination and communication between AMH, CAMHS and CSC, it was felt necessary to develop a service which could build links between existing services, for the benefit of the family. Identifying and supporting the children within these families, in partnership with a nationally respected voluntary sector organisation (NSPCC), was considered the most appropriate way forward.

Who are stakeholders?

- Central and North West London Child and Adolescent Services
- Adult mental health services
- NSPCC

Do/did the stakeholders think it was a good idea?

The Parental Mental Health Service made a film, available on DVD, entitled, 'Still Waiting for an Answer' documenting its experiences to capture and share the learning for the benefit of clinicians and commissioners. **The DVD illustrates how a pragmatic approach to service design and partnership work can respond to the needs of families where a carer has a mental health problem.**The need to develop better working strategies between partner agencies (AMH/CSC/CAMHS) for the benefit of families, is well documented in the film, however the role played by users of services in the project's development is unclear.

What are/were the desired outcomes?

Specifically the service aims to act as the interface between AMH, CSC and CAMHS to provide a dedicated clinical service for children and young people whose parents have mental health problems, in partnership with the voluntary sector.

What was/ will be done to achieve them?

Process: A working party was formed by West London Mental Health Trust in response to awareness it was not meeting the needs of parents with mental

health problems. It approached the NSPCC, valuing the input of an independent voluntary sector organisation.

Based on an earlier piece of research carried out by NSPCC on the needs of children whose parents experience mental health problems, in another part of the trust, it developed the Parental Mental Health Service. This is a team at the interface of CSC and AMH.

Practice: When people who are parents are referred to the CMHT they receive a joint assessment by an adult practitioner and a member of the parental mental health team. In effect, NHS adult and child care practitioners work alongside NSPCC child protection workers to provide multi-disciplinary clinical services, including family therapy, parenting support, and play therapy for children. They draw up care plans together and take part in case reviews.

Members of the multi-disciplinary parental mental health team attends clinics, ward rounds and meetings held by AMH and CAMHS to ensure that users' parenting role and the needs of their children are considered in both settings, working directly with families alongside colleagues in other directorates and agencies where required.

What did stakeholders think about methods?

The film captures the positive responses of the stakeholders but the role of the person using services in the implementation of the project is not documented.

What have been the outcomes of this work – intended and unintended?

It addresses the main policy drivers in AMH, to target the most complex situations and in CMH to identify child mental health issues as early as possible. It recognises the need to work closely with CSC to achieve these aims.

The staff involved in the project report an increase in cross-boundary activities between AMH and CAMHS directorates and across partner agencies.
A user comments positively: ''They look at the whole picture – my children, and me with mental health problems.'

Feasibility

This model requires the commitment of senior managers across services to address the needs of this client group. Whilst not offering a template for the establishment of similar services elsewhere, because of the importance of local variables, they do offer a range of support to agencies interested in developing similar types of provision including clinic-based open mornings, facilitated workshops and consultation.

Think child, think parent, think family

Affordability

The video clearly recognises the difficulties of costing a preventative service such as this, in terms of the savings in other care sectors but emphasises the moral imperative to address the needs of families experiencing mental health difficulties

It was produced in response to the HSJ award won by the service in November 2004, where the judges recommended that this model of care was shared nationally across the NHS.

The Southwark Mental Health Family strategy

What is the idea?

It is an attempt to develop a family-oriented approach within adult mental health services which strengthens the link with children's services. This supports people who use services in their parenting role and improves the wellbeing of children whose parents are experiencing a mental disorder. To this end Southwark has developed a Mental Health Family strategy.

Why is this a good idea?

A range of national policy directives argue for the importance of ensuring that the needs and welfare of children are in the forefront of every public service. This has implications for users of services who are parents. They felt their role as parents was often overlooked and this created anxiety about seeking help because a perceived emphasis on risk might jeopardise their relationship with their children.

Who are the stakeholders?

The key contributions were from:
- users of services who are parents
- staff from children and families social services
- clinicians from CAMHS and adult mental health services
- workers in the voluntary sector.

Do/did the stakeholders think it was a good idea?

The available documentation suggests the initiative, although driven initially by the energy of middle managers, successfully captured the views of the stakeholder group, which was keen to see the parental role of those who use services acknowledged and addressed in policy development and service delivery.

What were the desired outcomes?

Key to the strategy is the vision that it is not enough to create specialist services for families and children whose lives are touched by mental ill health. A family approach needs to become embedded in mainstream mental health care. Adult mental health services in Southwark aimed to achieve this by:
- taking full account of the role of people who use services and their needs as parents, in clinical assessment and in developing care plans
- ensuring that parents with mental health problems have information about services available to support them in their parenting role and information about services to support their children
- improving liaison and multi-agency working with services for children and families in the borough, to include CAMHS, social services, children's centres, extended schools and voluntary sector organisations

Think child, think parent, think family

- ensuring that policies and procedures are in place to safeguard the children whose parents have a mental health problem
- creating environments within adult mental health services that are safe and welcoming for children, and providing child care facilities that can be accessed when necessary
- developing services for children whose parents have mental health
- problems to enable them to understand the issues and receive support as young carers
- supporting people who use services through conception advice, pregnancy, childbirth and the post natal period
- improving the accessibility of services and outreaching to agencies
- supporting children and their parents
- taking account of cultural background and linking in with local BME services.

What was/will be done to achieve them?

Process: A Family Strategy Group was set up to develop the approach, comprising senior staff from adult mental health, Southwark MIND, CAMHS, children's social care and Family Welfare Association[8] (Newpin) representing managers, practitioners, users, parents, commissioners and psychiatrists. Contributions were also received from a carers project. The key themes identified included:

- support to users/partners in their parenting role
- support to children of parents with mental health problems
- improved access to mental health services
- safeguarding children
- developing approach within community mental health practice,
- consulting and working with users who are parents
- promoting joint work between adult mental health services and CAMHS.

Sub-groups were established to review existing provision and identify gaps. Opportunities for service development were considered by the Family Strategy Group and efforts made to actively promote collaboration between services. Central to the strategy development was a commitment to regular and systematic review processes which ensured a continued focus on the needs of people who use services.

The Mental Health Family strategy was officially launched and an implementation group formed to agree an action plan and timescales for the various work streams identified.

Further embedding of the Mental Health Family Strategy is planned by way of a series of training events. These include building on the existing Crossing Bridges training for all staff and adapting the Family Partnership training developed by Centre for Parent and Child Support[9], for AMH staff.

Funding is being sought for posts to develop a parents forum and to produce a film aimed at helping professionals understand the needs of people who use

services who are parents. These developments will hopefully contribute to the culture change necessary to make the Family Strategy, a reality.

Practice: The development of the Southwark Mental Health Family Strategy 2007–2010 (published in 2008) provided an opportunity to review existing service provision and strengthen the links with children's services to support family life. It has been able to evidence a range of initiatives, which go some way to meet its objectives.

In terms of mainstreaming a family approach in adult mental health services, achievements include:
- adoption of trust-wide children's visiting policy
- plans to implement a borough-wide CAMHS consultancy to AMH
- provision of resource packs, detailing support services for children and parents in the borough, to all mental health teams
- appointment of a senior AMH manager services to lead on children and parents issues.

The early intervention goals have been addressed by:
- provision of staff providing psychological interventions, social support and outreach services to children's centres
- collaboration with CAMHS to provide consultancy and training to children's centre staff, strengthening opportunities for joint working.

In terms of supporting children whose parent(s) have a mental illness, a range of voluntary sector projects provide services geared to meet the needs of children affected by parental mental health. For example:
- Newpin (run by Family Action) offers parental support to parents with mental health problems who have a child under 5.
- The Building Bridges project, which is jointly commissioned by CAMHS and AMH commissioners, works with children of parents with a mental health problem, to help them make sense of their parent's problems and help the family overcome them.
- There is also a borough-wide Young Carers project in Southwark providing a service to children caring for relatives, including those with mental health issues.

Objectives in relation to conception, pregnancy, birth and the postnatal period, include:
- The provision of specialist perinatal mental health services working with both King's and Guy's and St. Thomas' maternity services.
- Southwark women with serious mental health problems have access to a specialist mother and baby unit.
- The Family Action Newpin perinatal project provides outreach and drop-in support to vulnerable new mothers and mothers-to-be, with the aim of improving their mental health and relationship with their baby.
- An intensive health visiting project aims to promote access for people who use mental health services.

Think child, think parent, think family

The existing joint service protocols to meet the needs of children and unborn children whose parents or carers have mental health problems, substance misuse problems and/or disabilities or who may be affected by domestic violence, went some way to meet the Safeguarding children objectives.

The increased emphasis on the impact of parental mental health on the family, has in turn influenced service development and commissioning within AMH and partner agencies, leading to increased consideration of collaborative ideas to meet 'family need'.

In order to maintain a focus on the continued inclusion of people who use services in evaluation and monitoring the several initiatives have been explored, such as enlisting the support of SURE (Service Users Research and Evaluation) based at the Institute of Psychiatry and adopting the Service User Monitoring process developed by the Sainsbury Centre for Mental Health.

What did stakeholders think about methods?

The available documentation suggests that stakeholder representation across the board has been maintained and continues to contribute to the ongoing refinement and implementation of a family strategy.

What have been the outcomes – intended and unintended?

The development of a mental health family strategy was used to unify the broad range of initiatives detailed above to encourage existing services and future developments to adopt a 'think family' perspective, which because it targets many fronts, results in changes to both service provision, staff attitude and user confidence, as evidenced by stakeholder willingness to remain involved as one of the national guidance implementation sites.

However, it was not possible throughout the process to engage male service users as effectively as hoped. Data from a male in-patient ward revealed that none of the users were in contact with their children. It was speculated that many men with mental health problems lose contact with children and this loss in their lives is unacknowledged. They found evidence of episodes of mild depression and anxiety as well as relapse of bipolar illness, suggesting men also experience mental health problems in relation to childbirth and parenting. Although the FWA[9] Newpin Fathers project provides individual and group support with parenting the need to review how better to support male service users in their role as parents has been identified.

Feasibility

This initiative appears to have been driven by committed middle managers in both AMH and CSC, but has the advantage of having been formally adopted by senior managers. It required a commitment to review existing service provision to families affected by parental mental illness and adopting a 'think

family 'approach to the process of addressing the gaps indentified. The perspective of people who use services has been maintained throughout. The process of bringing together key stakeholders, identifying common goals, reviewing existing provision and encouraging a 'think family' approach to service development and building in systematic reviews of progress is clearly replicable in other settings.

Affordability

The development of a coherent mental health family strategy has not been costed but is likely to form part of existing post holder responsibilities. The cost of developing services which are responsive to local need will reflect local resources. The longer term savings of a congruent family strategy which seeks to meet the likely needs of families affected by parental mental ill health at the earliest possible stage have not been costed.

What is the idea?

CHAMP is a parental mental health team in Tower Hamlets providing support to families where there is parental mental illness. The CHAMP project employs children's specialist workers who work jointly with allocated workers within the Community Mental Health Team (CMHT) and Children's Social Care. Consultation is available for cases where a parent might not meet the criteria for CMHT involvement. The primary aims of the project are to:

- ensure an early assessment of children's needs in full cooperation with the parent, whether a person using services or in a carer role, enabling parents and children to access appropriate community resources. The worker may take the role of 'lead professional' in relation to some children but will not perform a statutory child care role
- prevent multiple assessments by different agencies, avoid delay in accessing services and divert families from statutory social care
- reduce social isolation of both children and parents
- have a specific focus on improving school attendance, maximising achievement in school and increasing participation in out-of-school activities in line with ECM outcomes.

Why is this a good idea?

Several studies[10],[11] have reported that children with parents in mental health services have benefitted from having a person outside the home to speak to about their worries and fears.

Who are the stakeholders?

- Children's Workforce Development Council funded CHAMP for a 12-month pilot as part of the New Types of Worker programme. This was from July 2007 to August 2008.
- London Borough of Tower Hamlets in partnership with East London NHS Foundation Trust and Tower Hamlets PCT who now fund the project.
- The project has a steering group which includes representatives from voluntary agencies, PCT, CAHMS, Children's Services, Adult Mental Health and Education

Why do/did the stakeholders think it was a good idea?

Local need is high, with a number of children in the borough affected by parental mental illness. It had been estimated that at least 400–500 children in the Borough of Tower Hamlets have parents who are service users in the Adult Mental Health Teams (2007). Subsequent research undertaken by the Children's Specialist suggested that these figures were an underestimate and the number for the borough is nearer 600. These parents were diagnosed with 'severe and enduring' mental illness and had often had repeated hospital

admissions. Many of these children remained hidden from services as families were anxious about the involvement of statutory services and did not readily or easily access community, other health or statutory supports. There had been a number of serious case reviews where parental mental health difficulties had significant implications for the welfare of children[12].

What are/were the desired outcomes?
The anticipated positive outcomes for children, young people and parents/carers include:
- ensuring early assessment of children's/young people's needs and preventing multiple assessments by different agencies
- diverting families from statutory social care unless there are significant concerns about the child/young person's welfare
- enabling children and parents to access appropriate community resources
- reducing social isolation for both children and parents
- improving school attendance
- maximising achievement in school/positive experiences of school/providing help with school work
- increasing participation in out-of-school activities/social/holiday activities
- ensuring that children are safe and that health and emotional wellbeing are being provided
- meeting children's needs through early non-statutory intervention and direct referral to appropriate community resources, health and education provision
- establishing relationships with a trusted adult/befriender/someone to talk to
- establishing positive peer relationships
- providing information for children when their parents/carers are unwell.

The anticipated positive outcomes for the New Types of Worker, their colleagues, managers and service commissioners include:
- for the Children's Specialist to undertake a lead professional role for some children but not performing a statutory child care role
- influencing the culture in community mental health teams and the mental health trust toward greater family support
- increased understanding and awareness amongst children's services, particularly schools of the stigma and social problems associated with chronic parental mental illness
- the development of skills in working across traditional agency boundaries and to increase understanding of the skills, knowledge and qualities needed to make such work possible
- to put in place the necessary agreements with all relevant partners
- to establish relevant partnerships
- to establish appropriate management and supervisory structures including a steering group.

The anticipated positive outcomes from the project for the wider children's workforce include evaluation and dissemination of the knowledge and skills

gained in the project in such a way, that the challenges of cross-agency working at the interface between adult mental health and children's services are understood and lead to more informed ways of working and improved services to families

What was/will be done to achieve them?

Process: The borough had a coordinator for Children in Families with Mental Illness who has undertaken extensive work to foster interagency links with all community mental health teams over several years. She is a member of the Mental Health Trust Safeguarding Children committee.

The borough also has a long-standing and strong partnership with Family Action, an organisation providing intensive home-based support to a small number of families referred by the Adult Community Mental Health Teams. This service was jointly commissioned by Adult Mental Health and Children's Services.

Practice: For the co-ordinator this has involved:
* regular consultation to adult community mental health teams within the borough
* joint one-off visits to families to support assessment
* pre-birth planning
* supporting liaison between relevant agencies and service managers
* child in need review meetings in schools, etc
* reviews of joint working
* parenting and mental health workshops
* development of resources
* teaching on various multi-disciplinary and inter-professional courses
* advocating and raising awareness for this group of vulnerable children
* running a group for children and young people including holidays, trips/outings and group activities.

Children's Specialist workers do not take on statutory responsibility for cases either as care coordinators or in terms of statutory child care.

The coordinator now has a more strategic role, whilst the Children's Specialist post, on the other hand, was based in one of the four Adult CMHTs and was designed to have more direct involvement with children and parents/carers. The post holder was therefore able to provide a continuous presence and consistent follow-up for families.

What did stakeholders think about methods?

Members of the steering group acknowledged the benefits of the current CWDC funding for the project. The need for the project had been acknowledged for a long time and the NToW programme offered a very valuable opportunity to establish the project and to gather evidence to support the wider roll-out of the work within Tower Hamlets.

What have the outcomes been – intended and unintended?

CMHT staff were asked as part of an evaluation of the project if the post had an impact on their work. For the most part, responses were positive and helped with:

- knowledge of services where the Child Specialist is seen as an expert in the field, with a finger on the pulse of all resources available to the clients, as well as a liaison between the multitudes of services that tend to be involved
- access to child – the Child Specialist has more skills when dealing with children and they help to identify the various needs of children
- overall caseload – allowing the CMHT worker more time with their client because the children's needs are being looked after and there is more focus on each individual involved rather than a split focus between the two
- doubts raised about the Child Specialist role concerned the capacity to perform more therapeutic techniques with clients and concern at the lack of availability of opportunities for children to discuss fears or worries about parents.

When asked about their contact with the Child Specialist, all seven families rated their satisfaction with his input at 10/10. Four families were happy with the frequency of their contact with him and three would have liked more frequent visits (Appendix 8). Children were asked how they feel when the Child Specialist worker visits. All four children under the age of five chose the option 'happy', as did six of the seven aged 5–12. Of the teenage children present at interview, five out of eight said they felt 'happy' and three chose 'I don't care'[13].

Since CHAMP's funding has been mainstreamed, it has expanded to incorporate a project coordinator, two full-time Children's Specialists and a part-time specialist teacher from education employed to improve communication between schools and services and to do direct work with children and training with staff within schools.

Feasibility

Local need and the views of parents supported the development of this project. This was backed up by research and national drivers and has enabled families to benefit from input they otherwise would not have received. The project clearly benefitted from the New Types of Worker programme and has been able to demonstrate the importance of working across traditional service boundaries.

Affordability

Initial costs of CHAMP were £60 000.

Think child, think parent, think family

Footnotes for case studies

[1] Campbell A. S. (2004), 'How was it for you? Families' experiences of receiving Behavioural Family Therapy', *Journal of Psychiatric and Mental Health Nursing* 11, pp 261–267

[2] Research, Evidence and Evaluation department of the National Children's Bureau (NCB) conducted a wide-ranging evaluation of the project (Oct 2006 – March 2008 http://www.pmhcwn.org.uk/documents/ Evaluation%20of%20The%20CAPE%20Project%20Final%20Report.pdf)

[3] Aldridge, J and Becker, S (2003) *Children Caring for Parents with Mental Illness: perspectives of young carers, parents and professionals.* Bristol: The Policy Press

[4] Parents in Hospital ; How mental health services can best promote family contact when a parent is in hospital – Summary Report –July 2007, Mental Health Commission, FWA, Barnardo's, CSIP.

5 Building Bridges **http://www.dh.gov.uk/en/Publicationsandstatistics/ Lettersandcirculars/Healthserviceguidelines/DH_4018062**

[6] Morris, J. Family Welfare Association, Building Bridges Model – Evaluation, July 2007, **http://www.family-action.org.uk/ uploads/documents/FA%20Building%20Bridges%20Evaluation.pdf**

[7]The Action 16 Group was set up to oversee the implementation of Action 16 of the SEU which stated the importance of working strategically to promote the mental health and social inclusion for parents with mental health difficulties and their children

[8] Now Family Action

[9] Family Partnership Training, developed by Crispin Day and Hilton Davis, Centre for Parent and Child Support, South London & Maudsley NHS Trust CAMHS Health Service Research Unit, Institute of Psychiatry, King's College, London: National Academy of Parenting Practitioners, UK

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[12] Paget, B., The Children and Adults Mental Health Project, London Borough of Tower Hamlets and East London and City Mental Health Trust, Organisational Case Study Final Report - January 2009 (CPEA).

[13] Evaluating the Role of a Child Specialist Within a CMHT

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UNICEF Convention of the Rights for the Child.

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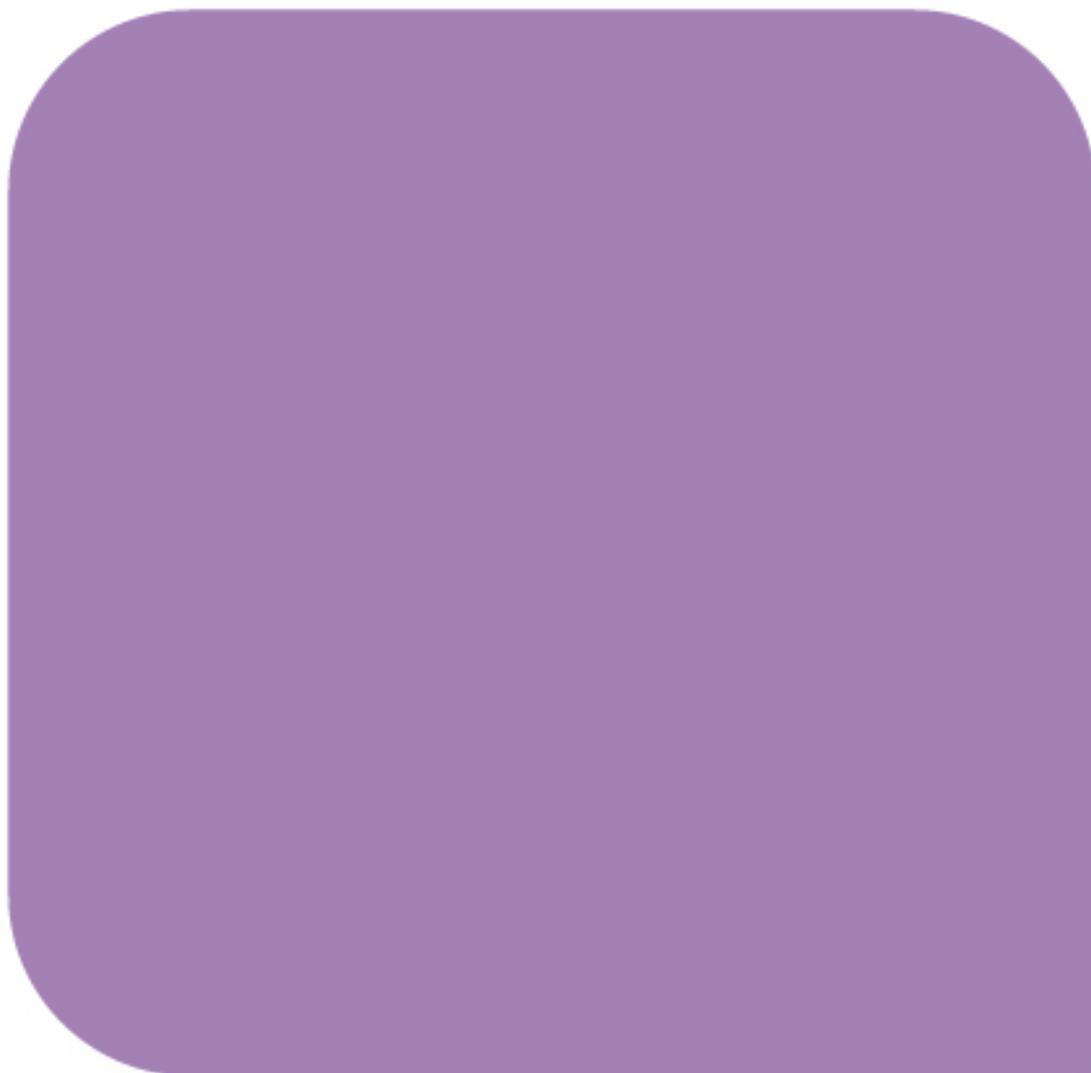- University of York, Social Policy Research Unit

Consultation feedback

The results of the consultation will be placed on the website in August 2009.

Appendices

Please go to the website to access the appendices.

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