Think Family NI Audit in Adult Mental Health and Children's Services

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August 2020

Executive Summary

The Think Family NI initiative, led by the Health and Social Care Board, aims to promote family focused practice, across teams, services and Trusts, to support families where there are parental mental health and/or substance use problems.

The Health and Social Care Board commissioned this case file audit to identify how health and social care staff were routinely identifying and responding to families' needs across Children's, Mental Health and Addictions services. The audit also explored the use of some of the specific Think Family NI initiatives and resources (such as the Joint Protocol, the Family Model A5 cards and the Children and Young People's leaflets).

The relevant research literature identifies a range of barriers and enablers to integrated, family focused practice. The barriers include: the complex nature of mental health and substance use problems; variation in service responses; different practice models/paradigms; professionals working in isolation; separate organisational structures; hierarchies of services/needs; worker's confidence; confidentiality; not listening to and acknowledging children's experiences; and not fully involving families. Enablers include: taking responsibility; physical proximity of adult and children's services; appropriate training and increasing workforce capacity; investing time to develop the professional network; practice style and consistency of processes; building confidence; building in time; assessing parental capacity; offering practical support; the role of other agencies/care providers; resources; promoting models of best practice; evaluation and research; and more and better quality data.

The case file audit included a total sample of 120 files made up of 30 files (10 each from Children's, Mental Health and Addictions services) from four of the five Trusts (one Trust declined). It was possible to complete the audit tool, which had been designed specifically for this project, with 108 of the files representing a total of 103 families.

Key findings include: the complexity of the issues; the importance of the social determinants and poverty-aware practice; workload and communication; the need to measure needs and outcomes; there are some excellent examples of good practice; but also examples of missed opportunities. A key theme in the findings was the complexity of families' needs and the complexity of the response by services. Families tended to have a range of issues and had engaged with an average of nine different services (with a range of one to 23 services).

The findings of this case file audit have reinforced how complex effectively supporting families can be, that there are many examples of good practice but there is an ongoing need to further promote family focused practice. The implications of the audit for policy and practice can be considered in five main overlapping themes: policy and service development; promoting joint working; training; information; and involvement.

Acknowledgments

The team would like to thank Sharon Crawford and Joanne Carey in the Northern HSCT for facilitating the pilot of the audit and the Research Governance units in each of the four Trusts who advised us on the content of the audit tool.

We are also extremely grateful to the teams from across the four Trusts who identified files for inclusion and made arrangements for conducting fieldwork, facilitated by Kerry McVeigh (Belfast), Sharon Crawford and Joanne Carey (Northern), Linda McConnell and Yvonne Russell-Coyles (South Eastern) and Darren Strawbridge (Western).

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Recommend citation: McCartan, C., Bunting, L., Davidson, G., Devaney, J., Donaghy, M., Duffy, J. and Grant, A., (2020). *Think Family NI Audit in Adult Mental Health and Children's Services*. Belfast: Queen's University Belfast.

Introduction

The Think Family NI initiative began in 2009 and, since 2012, has been developed and implemented within a regional action plan under the structure of the Children and Young People's Strategic Partnership. Its primary aim is to promote collaborative working across agencies and enhance multi-disciplinary approaches to supporting families where there are parental mental health and/or substance use issues. In 2011, the Health and Social Care Board (HSCB) developed a joint protocol for Adult and Children's Services to respond to families where parents had mental health and/or substance use problems. (In this report, we mainly use parental mental health problems to refer to both mental health and/or substance use problems). The protocol sets out the standards to inform and involve service users and families and requires that "Parents should be helped to understand their mental health issues, their treatment plan, and the potential impacts of mental health issues on their parenting, the parent-child relationship and the child." (Health and Social Care Board, 2011, p. 9).

Queen's University Belfast (QUB) was commissioned by the HSCB to conduct an audit of case files from a random sample across Adult and Children's Services in the Health and Social Care Trusts (HSCTs). The aim was to assess whether the information resources made available by the HSCB (such as the Think Family NI's Children and Young People's leaflets and the A5 cards) were being used. It also sought to identify, more generally, how health and social care staff were routinely identifying and responding to adult mental health needs and children's needs in their assessments, care plans, interventions and reviews. This included looking for evidence of the level/nature of contact with children, providing early intervention, involving parents and children in the screening/assessment process, being proactive in developing good relationships with their counterparts in other agencies to promote joint working, and helping service users and family members understand the impact of mental health problems on the family. The audit also looked for evidence of an understanding of the benefits of using a family focused approach. Cases that had been open within a 12-month period were examined and, where possible, dating back five years to reflect the period of the Think Family NI implementation.

The report is set out in six sections. Firstly, it considers the context of parental mental health problems and the development of family focused practice. It then examines the difficulties and barriers to interagency collaboration. Section 3 then outlines some of the international evidence of how to enable and promote family focused practice. We then present the methodology and results of the audit. Section 5 makes recommendations from the findings of the audit. Finally, we will summarise our conclusions.

Section 1: Background

1.1 The prevalence of parental mental health problems

Almost one quarter of children in the UK live with at least one parent with a mental health and/or substance use problem (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012). At 29.8%, Northern Ireland has the highest prevalence of maternal mental health problems in the UK (Abel et al., 2019). The complex nature of parental mental health problems, and the potential impact for the whole family, presents challenges for health and social care services. Social work, with its role across child welfare and adult services, has a key role in understanding, highlighting and responding to both the wider determinants of parental mental health and how services respond to support families. This case file audit therefore focused mainly on social work case files but the scope includes the data that those files provide about multi-disciplinary and inter-agency working.

1.2 The social determinants of mental health and substance use

While genetics and other bio-medical factors may play an important role in the transmission of mental health problems (Bouchard Jr & McGue, 2003), psychological processes and social factors including poverty and domestic violence (Hansson, O'Shaughnessy, & Monteith, 2013) are important too and arguably may be more amenable to intervention. The social determinants of mental health are well established (Allen, Balfour, Bell, & Marmot, 2014). Social inequality is a risk factor for mental health problems and those experiencing poverty and other inequities suffer disproportionately (Allen et al., 2014). Unemployment, precarious employment, employment conditions and low income are routinely linked to psychological distress (Amroussia, Gustafsson, & Mosquera; Han & Lee, 2015; Reibling et al., 2017). Neighbourhood deprivation has been associated with worse mental health, higher levels of psychiatric prescriptions and higher risk of being hospitalised for mental health problems controlling for individual level socio-economic status (Crump, Sundquist, Sundquist, & Winkleby, 2011; Santiago, Wadsworth, & Stump, 2011; Sundquist & Ahlen, 2006). The impact of poverty on food insecurity and poor diet and nutrition have also been linked to poorer mental health (Davison, Gondara, & Kaplan, 2017; Leung, Epel, Willett, Rimm, & Laraia, 2014; Martinez, Frongillo, Leung, & Ritchie, 2018).

Recent UK research has also established that there is a strong social gradient in child welfare interventions (Bywaters et al., 2020). In Northern Ireland, children living in the most deprived areas are six times more likely to be placed on the Child Protection Register and have a four times higher rate of becoming looked after than those living in the least deprived areas (Bunting, McCartan, & Davidson, 2017). Close to 70% of children in Northern Ireland live in

the most deprived 40% of neighbourhoods, a higher proportion than in other parts of the UK (Bywaters et al., 2020).

Parental mental health problems are common in child protection. Parental mental problems have been cited in pre-hearing child protection cases of child neglect, domestic violence, financial and accommodation difficulties, unrealistic expectations of children and risk-taking behaviours in children (Sheehan, 2004). Children of parents with substance use problems commonly experience emotional and behavioural problems but do not routinely receive services (Contractor et al., 2012). There is, however, some encouraging evidence that if the right kind of support is made available, the outcomes for children can be much better (Siegenthaler, Munder, & Egger, 2012).

1.3 *The impact of parental mental health problems*

A significant number of children living with a parent with mental health and/or substance use problems will experience cognitive, emotional, social, physical and behavioural problems on a short or long term basis (Mennen et al., 2015; Andrea Reupert & Maybery, 2016). Between 25-50% of these children will develop a mental health problem during childhood or adolescence and 10-14% will be diagnosed with some form of psychosis at some point in their lives (Beardslee et al., 2012). Children in these families are more likely to fail to thrive (Advisory Council on the Misuse of Drugs (ACMD), 2003), miss developmental milestones, experience poor attachment (Stanley, Cleaver, & Hart, 2010), and are at risk of neglect and abuse (Munro, 2011). Although it is not inevitable that problematic substance use affects parenting capacity, it can be a significant factor in child deaths and serious injuries (Oxford Brookes University Institute of Public Care, 2015). Mental health problems are present in many child protection cases and can affect basic parenting provision including feeding, clothing, nurturing, maintaining discipline and supervision as well as some evidence for emotional detachment, disinterest and unrealistic expectations of the child (Jeffreys, Rogers, & Hirte, 2011). The temporary and episodic nature of some mental health problems can create further complexities for families and services. Concerns about the potential implications about being open about mental health and/or substance use problems can create further barriers. For many people, complex trauma is an underlying issue which may not be fully acknowledged or addressed by the family or services. There may also be gendered approaches in decision-making and a range of other potential biases relating to issues such as ethnicity, age, disability, sexual orientation, poverty and class. Professionals may be more likely to report a parenting issue if the mother rather than father was experiencing difficulties (Liangas & Falkov, 2014) and fathers with mental health problems are often ignored (Boursnell, 2014).

1.4 Family focused practice

There is convincing evidence that family focused practice can be beneficial for everyone in the family when parents present with mental health and/or substance use problems (Cooper & Reupert, 2017). While policy, guidelines and education are important enablers of family focused practice, none are effective on their own (Grant & Reupert, 2016; Liangas & Falkov, 2014; Royal College of Psychiatrists, 2011). Providing support for families where parental mental health and/or substance use problems are present is complex. Long term, multifaceted, implementation strategies, at multiple levels in an organisation, are needed (Anne Grant & Andrea Reupert, 2016; Camilla Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014). An agreed definition of family focused practice that can be used across services and countries alongside a standardised and consistent approach to measuring family focused practice outcomes is also required (Lagdon et al., under review). There are a range of barriers that can impede effective interagency collaboration.

Section 2: Barriers to integrated service delivery

There may be a range of factors related to the complexity of adversities the family may be experiencing and also a range of additional barriers created by the way services are organised and how they respond. These include:

- The complex nature of mental health and substance use problems
- Variation in service responses
- Different practice models/paradigms
- Separation in professional territorialism
- Devolved responsibility of adult and children's services
- Hierarchy of services
- Confidence
- Confidentiality
- Listening to and acknowledging children's experiences
- What families want

It should be acknowledged that the literature reviewed in this section and in Section 3 is from a range of contexts and from over the past, approximately, 20 years so all of the issues identified may not be transferrable or current for the Northern Ireland context.

2.1 *The complex nature of mental health and substance use problems*

The prevalence and complex nature of mental health problems is significant. In the UK, it is estimated that 10% of mothers and 6% of fathers have mental health problems (Mental Health Foundation, 2016). A more balanced understanding of the nature of serious and persistent mental health problems is needed (Bibou-Nikou, 2003; Darlington, Feeney, & Rixon, 2005b). It is often cyclical and episodic, may be relatively mild at times and not 'severe and enduring' enough to warrant maintained contact with services (Loshak, 2007). Within a supportive family, it may have little or no effect on the child (Carpenter, Patsios, Szilassy, & Hackett, 2011). Some parents have described the need for the social work profession to have greater understanding of the risks that family members face, given that the impact of mental health problems on parenting and the subsequent care for children can change regularly (Boursnell, 2014). The focus on risk when a parent is unwell may fail to meet the family's real needs and can create barriers to treatment engagement (Boursnell, 2014), however, planning and putting supports in place can be difficult when problems change rapidly. Support needs to be ongoing and be ready to be mobilised to the required intensity when necessary (Darlington et al., 2005b).

Some parents may find it difficult to accept they have a mental health problem (Bibou-Nikou, 2003). 'Acceptance' can be key to recovery, enabling engagement with treatment services but the pattern of mental health problems can be difficult to predict and liable to change over time. It can be characterised by periods of denial, acceptance, and resignation and, the parent's "lack of awareness of the impact of their own illness, and the possible failure to differentiate between their own and their children's needs, makes a real acceptance even of primary preventive service difficult to achieve." (Bibou-Nikou, 2003, p. 260). "[A]mbivalence is common for many conditions" (Berliner et al., 2015, p. 9) and as a result many children can remain unknown to services (Loshak, 2007). Parents may not consider that their mental health is a problem for their children (Contractor et al., 2012; Fjone, Ytterhus, & Almvik, 2009) or are reluctant to involve them (Maybery & Reupert, 2006, 2009; Sheehan, 2004).

Borderline personality disorder, although it may be an unhelpful way to characterise a parent's distress, describes a range of complex issues that seem to present specific challenges for effective service responses (Jeffreys et al., 2011; Sheehan, 2004). Nuances exhibited in other mental health problems may also present challenges for social work including depression and schizophrenia which can change parents' emotional responses to their children (Duffy, Davidson, & Kavanagh, 2016; Gorin, 2004; Murray, Halligan, & Cooper, 2010). Responses from services can feel superficial and inadequate for some parents (Jeffreys et al., 2011).

Parents with mental health problems have typically low rates of help seeking and may feel stigma and shame about their condition and may not disclose their parenting status (Darlington et al., 2005b; Phelan, Bromet, & Link, 1998) or the impact their mental health problems are having on their family or themselves (Biebel, Nicholson, Woolsey, & Wolf, 2016; Cowling & Garrett, 2012). Scepticism or mistrust of mental health professionals can also deter parents from seeking help (Contractor et al., 2012; Cremers, Cogan, & Twamley, 2014). Engaging with mental health services can be perceived as difficult and may be experienced as adding to the parenting load. Service providers may also have negative attitudes and beliefs about parenting capacity (Diaz-Caneja & Johnson, 2004).

Many parents have an understandable fear that their child will be removed, especially when they are very unwell, and can feel discriminated against when trying to access services (Alakus, Conwell, Gilbert, Buist, & Castle, 2007). Those reluctant to seek help, deterred by fears of child protection procedures, may therefore not have access to the potential benefit of family support services (Aldridge, 2006). Both parents and children may have a fear of the intergenerational transmission of mental health problems (Cooklin, 2013), with many parents having experienced their own parents' mental health problems (Power et al., 2015).

Unresolved childhood issues can also impact on their own ability to parent (Boursnell, 2014). Nonetheless, numerous studies have identified parenting as a rewarding and important part of life living with mental health problems and is often cited as the primary reason for seeking help (Bonfils, Adams, Firmin, White, & Salyers, 2014; Carpenter-Song, Holcombe, Torrey, Hipolito, & Peterson, 2014; Nicholson, 2010).

It is not only parents that can mistrust service providers, children can be suspicious of mental health and/or social services and can try to conceal their parent's problems or disturbed behaviour (Pölkki, Ervast, & Huupponen, 2005). Children's experiences of different approaches to parenting may also be limited and so, even when there are considerable difficulties, they may not be identified, by the child/ren, as problematic. Moreover, some children continue to be missed by safeguarding services because they feel protective of their family and do not disclose potential concern (Cooklin, 2013, pp. 234-235; Pölkki et al., 2005). Children can also feel frightened of being bullied or singled out by other children or adults, losing the closeness that they have had with their parent or fear that their parent will never recover (Cooklin, 2013). They may also share their parent's concern, possible founded on previous experience, about the potential negative consequences of being open with services.

The size, complexity and fragmentation of services, while it may be necessary to provide specialist intervention, can also be an issue. A co-ordinated, positive service response can be more difficult to achieve when there isn't a shared understanding of the nature of parental mental health problems and the need for child protection intervention (Darlington, Feeney, & Rixon, 2004). Where the family and the different professionals involved agree about what the issues are, collaboration can be more successful (Darlington et al., 2004) and considered more easy to manage (Jeffreys et al., 2011). There is some evidence that when professional collaboration across support services is lacking, this can also have an impact on the family, influencing how they think about and experience family problems, and negatively affecting intra-familial relationships and those with practitioners (Biebel et al., 2016).

Feeling supported and successful as a parent may help recovery but, at times, parents' recovery may be undermined by issues such as inappropriate policies, inadequate interventions, assumptions of others, and they may then at increased risk of child protection involvement, even child removal, (Friesen, Nicholson, Kaplan, & Solomon, 2009) which may further exacerbate their mental health problems. Some parents can feel they are offered too much support (Perera, Short, & Fernbacher, 2014).

2.2 Variation in service responses

Parents presenting with mental health and or substance use problems can experience a range of responses from social work and mental health professionals. Often dependent on the circumstances of a referral (e.g. GP consultation, mental health crisis or a child welfare concern), variation between services can be substantial. Children of parents with co-occurring substance use and mental health problems have been overlooked in behavioural health treatment (Finkelstein et al., 2005) and there is evidence that parents with substance use problems can be treated differently by child welfare services. Analysis of n=434,346 substantiated child maltreatment reports from the US 2012 National Child Abuse and Neglect Data System (NCANDS) examined the proportion and characteristics of reports involving problematic substance use that predicted referral to treatment as recorded in service plans (Steenrod & Mirick, 2017). Twelve per cent of maltreatment reports involved children with parental substance use problems (n=53,235) but only 19% of these cases (n=10,088) were referred to substance abuse treatment as part of their service plan. Children of parents with co-occurring emotional disturbance were three times more likely to be referred to treatment for problematic substance use.

It can also be important to understand how problematic substance use has developed, and that there can be serious, related health issues such as physical dependence and other physical health problems (Contractor et al., 2012). Treatment typically has long waiting times, is characterised by relatively brief interventions and may be un-coordinated with other services. Targeted efforts may help decrease waiting times, no-show rates and the need for hospitalisation while enhancing engagement, treatment participation, staff morale and team work (McKay, McCadam, & Gonzales, 1996; Szapocznik et al., 1988; Williams, Latta, & Conversano, 2008).

The US Child Welfare Information Gateway provides evidence for service delivery challenges (https://www.childwelfare.gov/). Despite large percentages of parents investigated by child protection requiring drug and alcohol treatment, the number of parents who receive services are small. This may be for a number of reasons. Some parents may not perceive that they have a problem or, even if they do, are not ready to engage with help. Many parents who begin treatment, don't complete it and there may be insufficient service availability or scope of services to meet existing need (Huebner, Young, Hall, Posze, & Willauer, 2017). There remains a critical challenge for child welfare professionals to meet legislative requirements regarding child permanency while allowing for sufficient progress in substance use recovery and the development of parenting capacity.

2.3 Different practice models/paradigms

Different agencies, services and professionals may bring different models and paradigms to practice that can potentially lead to conflict and/or inappropriate levels of support for families. The needs of different types of families and how 'family' is defined can vary in the mental health literature. There may also be different views on what constitutes risk to a child when a parent has mental health problems and this can impede the development of practices that provide information about the whole family and a more complete understanding of a family's functioning (Sheehan, 2004).

Maybery and colleagues examined family-focused practice differences in a range of professions working within adult mental health (Maybery, Goodyear, O'Hanlon, Cuff, & Reupert, 2014). Professionals (N=307) were invited to complete the Family Focused Mental Health Practice Questionnaire (FFMHPQ) from ten area mental services across Victoria, Australia. No significant differences were found between professions in perceptions of organisational support and policies for supporting practice in the workplace, however, differences were found in direct work with families. Different levels of support were offered to carers and children and assessments of the impact of parental mental health on children varied, as did referrals for family members to support programmes. The main differences were found between psychiatric nurses and social workers. Social workers were much higher in confidence than nurses and psychiatrists and were more willing and able to provide family focused practice.

Within nursing practice, there is some evidence that the application of person-centred care may be insufficient in meeting the needs of children and families with parental mental health problems (Foster, O'Brien, & Korhonen, 2012; Maddocks, Johnson, Wright, & Stickley, 2010). A systematic review of family focused practice within mental health services found that there was a lack of definitional clarity and theoretical integration (Foster, McPhee, Fethney, & McCloughen, 2016) and very few theoretical or practice frameworks to show how families might be included across different mental health settings. Mental health nurses for example may have competing needs to reconcile including supporting parents during visits to their children, being mindful of the therapeutic alliance and the risks associated with the parenting role; the nursing model may prioritise person-centred care over family-centred (Maddocks et al., 2010).

Within the psychiatric profession, the therapeutic alliance is important and professionals may be concerned about jeopardising this relationship (Maybery & Reupert, 2009). It may be that the wider family context is also an important factor in the parent's mental health problems

(Foster et al., 2016). Innovative approaches to family treatment may be linked to workers' attitudes, skills (or deficits), knowledge and profession-centric training because of a narrow focus on the individual therapeutic alliance (Maybery & Reupert, 2009).

Qualitative research has been conducted to explore decision-making across different disciplines. Using a vignette example, workers from across the different agencies made relatively complex assessments and all proposed a multi-agency response although there were subtle differences between agency types (Darlington, Healy, & Feeney, 2010; Rouf, Larkin, & Lowe, 2011). Non-statutory intensive family support workers were more likely to suggest early notification to statutory bodies and non-statutory workers saw themselves in a better position to develop trust and build relationships with family because they weren't directly involved in seeking care orders.

2.4 *Separation in professional territorialism*

Despite best efforts, staff may continue to work in isolation of other disciplines (Cowling & Garrett, 2012; A. Grant et al., 2018) with a desire to guard one's professional territory but also careful not to trespass on another's, particularly if that service is seen as 'responsible' (Baistow & Hetherington, 2004). Coates' interviews with mental health workers described child protection workers as very different people, one stating that, "I cannot work with [CP]" (Coates, 2017, p. 5) inhibiting collaborative working because "their own professional identity, or even personal identity, may clash with that of child protection workers." (Coates, 2017, p. 5). Darlington found that workers had a high regard for each other as professionals, and low levels of mistrust, however there was a perceived lack of training (Darlington, Feeney, & Rixon, 2005a). Jeffreys and colleagues (2011) also found tensions between workers caused by an adult-centric approach.

There are difficulties balancing parent-child needs (Darlington et al., 2005b). It is a worry for parents when children aren't with them and mental health workers will advocate for parents' wellbeing if children are at risk of being removed. Some child protection workers may perceive that mental health workers withhold information about a parent's condition and their parenting capacity in order to protect the parent. The consequences of this can lead to a lack of coordination of care, risk of relapse for the parent, and a potentially adverse outcome for the child. Child protection workers felt an over-riding obligation to protect the child and in general "specialised services focus workers' attention on their own client" (Darlington et al., 2005b, p. 246). Child protection workers may struggle to find out accurate information about a parent's mental health status, confirming their concerns or obtaining advice about appropriate interventions from adult mental health professionals (Sheehan, 2004). The more specialised

the organisation of child welfare and mental health, the more likely to be barriers between services.

There remains some uncertainty over who has professional responsibility for the child in cases of parental mental health problems (Aldridge, 2006; A. Reupert & Maybery, 2008). Stanley and colleagues (Stanley, Penhale, Riordan, Barbour, & Holden, 2003) surveyed 500 professionals across social care, psychiatry, general practice and other support services to explore client advocacy and 90% of respondents reported they were advocating for only one member of the family. Exceptions to this were the police and GPs, with the majority of children's social workers advocating on behalf of the child. Adult psychiatrists and mental health social workers supporting adult family members can inevitably lead to conflict (Carpenter et al., 2011). The child protection role is complicated, having to consider the potentially contradictory nature of parent and child conflicts of interests (Bibou-Nikou, 2003).

2.5 *Devolved responsibility of adult and children's services*

Adult and children's services are sometimes under the responsibility of different management structures that can lead to separation in professional identity and responsibility. They can be governed by divergent policies and procedures informed by different paradigms and perspectives (Coates, 2017; Darlington et al., 2010; A. Grant et al., 2018). This structural separation between mental health and child welfare services can at times be characterised by ways of thinking and working in separate silos in mental health and child protection (Coates, 2017). Although collaboration tend to be viewed positively, and can lead to improved outcomes for the client, workers can report difficulties around communication, confidentiality, clarity of professional roles, boundaries and leadership and a competing primary focus. While contact may be good between services, it may not always be real collaboration (Darlington et al., 2005a).

Living with a parent with mental illness may expose a child to a degree of risk of abuse and neglect however both adult mental health services and children's services share a responsibility for safeguarding children and promoting their welfare. There is also some evidence, from the English context, that, while joint guidance is important, it may be insufficient on its own to achieve substantial positive change (Carpenter et al., 2011). Some mental health professionals may not see supporting children as their responsibility (Cooklin, 2013) or view that focus as in potential tension with helping parents (Slack & Webber, 2008).

2.6 Hierarchy of services

There is some discussion in the literature of a perceived hierarchy, at times, between Children's Services and Adult Services, which places Children's Services as more important. This hierarchy can put strain on relationships but by being better informed about the roles and responsibilities of other agencies, this could be avoided (Alakus et al., 2007). There is some evidence that mental health and drug and alcohol workers feel undervalued by child protection workers; child protection "don't fully appreciate the impact of depression and anxiety on someone" (Coates, 2017, p. 5). In order to counteract this culture of professional hierarchy or territorialism, Anderson suggests that practitioners stop viewing themselves as 'experts' and instead shift the focus from providing 'expert' intervention to developing partnerships and working collaboratively (Anderson, McIntyre, Rotto, & Robertson, 2002).

2.7 Confidence

Some practitioners lack the confidence and relevant skills to support their decision-making and response to families (Jeffreys et al., 2011; Maybery, Goodyear, Reupert, & Grant, 2016; Maybery & Reupert, 2006; Reupert & Maybery, 2008). Maybery and colleagues (Maybery et al., 2016) found that worker confidence was an important predictor of family focused practice. Professionals expressed considerable anxiety about parenting issues and children's understanding of them and found treatment, drugs, compliance and medication side-effects easier topics to talk to parents about (Bibou-Nikou, 2003). Many adult mental health staff know little about infant mental health, similarly, adult mental health staff can feel that child protection staff are not well informed about mental health (Alakus et al., 2007). Practitioners may choose to ignore signs of mental health problems because they are not equipped to deal with them (Deakins, Seif, & Weinstein, 1983; Griffin, 1991; Thompson, 1990). Schuff and Asen's review of the clinical literature on adult mental health concluded that adult psychiatrists appeared to have little specific expertise on assessing parenting skills (Schuff & Asen, 1996). Cooklin reinforces this, "many mental health staff may shy away from trying to offer an explanation to children, fearing that their lack of training qualifies them from engaging with children, and workers with children commonly do not feel competent to discuss or explain mental illness" (Cooklin, 2013, p. 235).

2.8 Confidentiality

The principle of confidentiality can be a barrier in terms of sharing information between teams and fostering interagency collaboration (Baistow & Hetherington, 2004; Darlington et al., 2005a; Maybery & Reupert, 2009). Mandatory reporting in some countries has helped attitudes and practices towards confidentiality (e.g. Scandinavia) (Alakus et al., 2007; Baistow & Hetherington, 2004) but it is still a contentious issue (Royal College of Psychiatrists 2004)

and often considered to be an impediment (Carpenter et al., 2011). It may be difficult to gain realistic and consistent information about the parent's lifestyle when parents express anxiety about the action the agency would take once information is disclosed (Taylor & Kroll, 2004).

2.9 *Listening to and acknowledging children's experiences*

There has been some criticism of the position of children's rights across the Children's and Adult Mental Health Services interface (Monds-Watson, Manktelow, & McColgan, 2010). Monds-Watson and colleagues (2010) have considered how mental health and family and children services practise under the United Nations Convention on the Rights of the Child (UNCRC) through the lens of an inquiry into the deaths of a mother and child. The Inquiry found that although the mother had been treated for severe mental health problems, none of the mental professionals or children's services personnel attempted to formally assess the current risk to the child, no special arrangements were made to monitor the interaction or follow up made. Monds-Watson and colleagues concluded that service provision for families with parental mental health problems often contravenes the UNCRC, particularly the right for children to be heard. Some countries have adopted legislation which place children's rights within the context of parental mental health problems including Norway's 2010 Health Personnel Act which has led to children being recognised legally with next of kin rights to information and follow-up where a parent has mental health and/or substance use problems. Pölkki's interviews with children and adult children of parents with mental health problems (Pölkki et al., 2005) found that children had not been informed about their parent's mental health and observed the children found it difficult to talk about their lives. Younger children in the sample were able to make detailed observations and vividly described parents' behaviour but demanded to know more about their parent's mental health. CAMHS will only see a tiny proportion of children affected by parental mental health problems (Cooklin, 2013). Addressing the mental health needs of children is also important (Biebel, Nicholson, & Woolsey, 2014). Indirect effects of parental mental health problems may restrict children's friendships and social activities and the child may assume caring responsibilities that are inappropriate (Carpenter et al., 2011). Children can be ambivalent and reluctant to engage in treatment and this behaviour can be seen as a barrier to treatment, either refusing to see the mental health professionals or not engaging (Contractor et al., 2012). Engaging young people in treatment is often a challenge, providing more information prior to therapy may allay fears (Contractor et al., 2012). Children of parents with mental health problems often fear for themselves, their parent/s and the rest of their family. They may also face financial hardship, possible separation from their parent(s), disrupted care patterns and education, with increased risk of reduced life chances (Cooklin, 2013).

***2.10** What do families want?*

Children

Offering clear and understandable information to children can be protective and can help build resilience (Bostock, 2004; Dyregrov, 2010; Koocher, 1974; Rosenheim & Reicher, 1985, 1986; Rutter, 1999), however, services for children are lacking (Nolte & Wren, 2016). Professionals can find it difficult to talk to children about the parent's prognosis, the potential for relapse and longer term outcomes because of individual response variations and the unpredictable nature of mental health problems (Bibou-Nikou, 2003).

Relatively few children and young people are directly talked to about their parent's mental health problems. Cooklin suggests that mental health staff should help the child with their own thinking, understanding and feelings around parental mental health rather than focusing on structuring or monitoring their environment. Children would rather see greater awareness of their needs rather than be singled out for counselling, "the response of professionals needs to be more that of a friendly 'colleague' or a respectful uncle or aunt, than the formal and inevitable hierarchical role in which a therapist or counsellor may be perceived by the child." (Cooklin, 2013, p. 231). Explaining to children about parental mental health may help the child to think things through, help professionals gain more information about their parent's problems, and encourage trust which in turn will help with the child's outcomes. Audits in the UK, Scandinavia and Australia reported children's views of their needs (Cooklin, 2013). They wanted a two-way explanation of parents' mental health problems providing clear and understandable information whilst acknowledging the child's role, access to a neutral adult who can be contacted in crisis and will act as the child's advocate. Children need opportunities to address and discuss their own fears about the mental health problems and have access to interventions to reduce their social isolation and help rebalance their role as a carer.

Children often provide critical crisis support to parents with mental health problems e.g. self-harm or psychosis as well as monitoring and assessing parents' emotional health and wellbeing and in some cases overseeing the safe administration of prescription drugs or just 'being there' for parents (Aldridge, 2006). Although Aldridge (2006) reported there was no evidence that children were put at risk of self-harm or neglect when parents self-harmed or made suicide attempts, they could well have experienced emotional harm. When parents have mental health problems, interventions of any kind may continue to be ineffective if they do not address the needs of families and they do not give due recognition to children's experiences, needs and contributions (Aldridge, 2006). Aldridge's research found that, "In most cases, even where health and social care professionals were visiting the family home, children's contributions and needs were overlooked or discounted." (Aldridge, 2006, p. 84). This was not

considered to be a deliberate oversight but a lack of recognition of events that lead to a child becoming a carer. Not all children of parents with mental health problems will become young carers however those who do want support and recognition of what they do (Aldridge, 2006). Children's needs are often modest, sometimes a five minute phone call helps (Aldridge, 2006). From a more positive perspective, Power's research with adult children of parents with mental health problems recognised potential for developing resilience through shared humour, regular family rituals and routines and open communication which helped to build better family connectedness (Power, Cuff, Jewell, McIlwaine, O'Neill & U'Ren, 2015).

The interaction between the impact of parental mental health problems and the age of the child(ren) needs further exploration with greater attention to tailoring age-appropriate interventions (Foster et al., 2016). Emotional peer support and connection is important (McNeil, 2013). International experts have identified the key knowledge needs for children on mental health literacy as: identifying information; making sense of parents' behaviour; coping better, and; respecting safety (Grové, Riebschleger, Bosch, Cavanaugh, & van der Ende, 2017). Cooklin offers some practical advice about approaching explanations of parental mental health problems with children at different developmental stages (Cooklin, 2013). The main aim should be to allow the parent's mental health to become discussable and no longer an unmentionable fear, and be defined as a technical event to in an attempt to distinguish the mental health problems from the child's experience. The explanation should help children recognise 'normal' and problematic behaviour and allow for the professionals to specifically acknowledge the child's contribution to the parent's care. Using technical age-appropriate language in a framework that explains the process of the mental health problems not a list of symptoms in a two-way process. Acknowledging children in the treatment process is really important.

Parents

Many parents complain that they don't receive an adequate explanation of their mental health problems (Cooklin, 2013) or know where to seek help (Alakus et al., 2007). The process of information sharing can be inconsistent and ambiguous and can be frustrating for parents when information is not shared between agencies (McNeil, 2013). Without clear and regular communication, families are at risk of receiving conflicting information from different agencies that can be distressing and consuming for families (Barbour, Stanley, Penhale, & Holden, 2002; Coates, 2017; Darlington et al., 2004). Agencies need to be able to tolerate chaotic behaviour and attendance characteristic of adults in mental health or substance use treatment services (Contractor et al., 2012; Darlington et al., 2005b) and provide ongoing support to anticipate changes in parents' capacity to cope to avoid repeated, highly intrusive, legally

driven interventions at times of crisis (Darlington & Feeney, 2008). Measuring gains for families is also difficult for professionals where communication is poor.

Responsibility for making sense of the mental health problems to children lies with the parent and this can be a real challenge (Nolte & Wren, 2016). Parents need support to help their children. It is important that workers listen to and acknowledge their client's perception of their ability to cope (Darlington & Feeney, 2008). It is important that expertise built on attachment and trauma theories are available for all parents that need support, not just those that meet clinical thresholds for diagnosis (Jeffreys et al., 2011).

Section 3: Enablers of family focused practice

There may also be a range of factors which enable family focused practice. This section provides a review of the international research literature about enablers of family focused practice. These may relate to family, service and/or wider context issues and include:

- Taking responsibility
- Physical proximity of adult and children's services
- Appropriate training and increasing workforce capacity
- Investing time to develop the professional network
- Practice style and consistency of processes
- Building confidence
- Building in time
- Assessing parental capacity
- Offering practical support
- The role of other agencies/care providers
- Resources
- Models of best practice
- Further evaluation and research
- More and better quality data

It should be acknowledged again that this literature covers a range of contexts and years so there may be limits to its transferability to the Northern Ireland context.

3.1 Taking responsibility

To promote and enable family focused practice, the knowledge of the risks for emotionally abused or stressed parents should be shared with all services and providers. Adult mental health services should put more emphasis on the parenting responsibilities of their clients with dependent children and have stronger links with family support and child welfare services. Mental health must be accepted as everybody's business although there must be a realistic acknowledgement of the opportunities and restraints (Sheehan, 2004).

3.2 Physical proximity of adult and children's services

When services are geographically separated, informal contact and chance meetings are less likely (Baistow & Hetherington, 2004); providing shared office space for an inter-disciplinary team can prove beneficial (Biebel et al., 2014). Physical proximity can also provide not only opportunities to promote collaboration (Jeffreys et al., 2011), but can help save time, resources

and create potential for theory development (Grant & Reupert, 2016). If siting services together is not possible, other approaches such as using different organisations' training venues, extending training to other organisations and involving consumers and carers in training presentations can help promote joined-up services (Carpenter et al., 2011; Reupert & Maybery, 2008).

3.3 *Interprofessional education, appropriate training & increasing workforce capacity*

Looking at how people are educated into the professions and how ongoing training is delivered also can provide opportunities to integrate systemic and multi-agency collaboration. Inter-professional education has been demonstrated to increase job satisfaction, help healthcare professionals resolve complex issues and tackle professional stereotypes while creating potential to establish effective working relationships across disciplines (Guraya & Barr, 2018). Joint training can help create a sound knowledge and skills base in order to strengthen support for vulnerable families (Darlington et al., 2010). The Laming Report was explicit about the need for interagency training to help professionals understand their respective roles and responsibilities, agency procedures and to develop a joint understanding of assessment and decision-making practices (Laming, 2009). Suggestions have also been made to promote family-focused practice in undergraduate and post-qualifying professional educational programmes and to encourage a strengths-based approach rather than an exclusively narrow child protection approach to identifying and assessing children's needs (Baistow & Hetherington, 2004; Grant & Reupert, 2016; Houlihan, Sharek, & Higgins, 2013). Staff will have unique training needs and these need to be addressed particularly when applying theory to practice and examining interactions with families (Biebel et al., 2014).

The World Psychiatric Association (WPA) produced *Guidance on the protection and promotion of mental health in children of persons with severe mental disorders* recommends that psychiatrists and related professions are educated about the affect of parental mental helth problems on children, and that psychiatric training is revised to increase awareness of patients as caregivers (Brockington et al., 2011). The guidelines also recommend that relevant assessments and interventions are incorporated into treatment rehabilitation. Pharmacological treatment should be optimised during pregnancy and special services planning made available for women with mental health problems intending to get pregnant to ensure women are supported during pregnancy and postpartum.

Training is more likely to alter clinical practice if it is endorsed and encouraged by management at all levels with a formal strategy and a champion to take it forward (Stanbridge & Burbach, 2007). There is evidence that multi-disciplinary, team-based training enables culture change

and practice for service development. Team managers should ensure that staff have managable workloads and appropriate supervision. Perera and colleagues (Perera et al., 2014) identify specific training and support for professionals in a range of areas: strengths-based work with families; working with challenging family members; how to assist families with communication and relationships; balancing potentially competing needs/wishes of family members; sensitive psychoeducation for partners; recognising and working with family violence in context of mental health and parenting, and; collaborative relationships with family violence, substance abuse and child protection. The importance of involving service users and carers in all aspects of services, including co-producing training, is also increasingly recognised and required.

Creating workforce capacity is crucial – identifying the relevant skills and recruiting a staff team with experience of working with adults and children and home-based services can be difficult. There are a number of different examples of key worker models to support families with parental mental illness (Biebel et al., 2014; Coates, 2017; Huebner et al., 2017). In parts of Scandinavia, identified personnel responsible for a child has become a required feature of service delivery. It has been mandatory since 2010 in Norway for someone in adult mental health wards to appoint a person with responsibility for children. Establishing child responsible personnel within adult mental health services may help safeguard children of parents with mental illness (Lauritzen & Reedtz, 2016; Lauritzen, Reedtz, Van Doesum, & Martinussen, 2015). The use of organisational champions to promote interagency collaboration and related interventions also appears to be effective (Reupert & Maybery, 2008).

Reupert and Maybery (2008) believe that capacity to raise mental health and child care professionals to respond better to families where a parent has mental health problems can be helped with education materials, community networks, professional development meetings and conferences (Reupert & Maybery, 2008). Comprehensive staff support strategies should also be developed that acknowledge the stressful nature of the work, with professionals often dealing with crises in family homes and where the “emotional intensity” can be “overwhelming” (Biebel et al., 2014, p. 213). Staff also need strong supervision and management that may enable staff to voice concerns about experiences of work.

Professionals also need practical tools for conducting assessments. There are good screening tools available for alcohol, but those for other substance use are less well developed and child protection workers are often not taught to recognise problematic substance use until concerns about parenting are evident (Deakins et al., 1983). For those families dealing with problematic substance use, this is just one aspect of the caregiver’s identity and the caseworker must be

able to empathise with the caregiver and the fear and pain that underlies their difficulties (Dore, Doris, & Wright, 1995). Adult mental health staff should be available to talk to children about their parent's mental health, and feel confident in explaining about the mental health problems and treatment particularly when a parent is admitted to an acute psychiatric facility, less acute admissions or community treatment. It is also important for these staff to liaise with the social work team and staff running young people carer groups (Cooklin, 2013).

Child care professionals must balance the safety of the child with the parent's need to take medications to keep them mentally and physically healthy to improve overall functioning. Caseworkers may need more information on the physiological effects of different kinds of drug use on functioning including cognitive impairment and how they may affect parenting behaviours. Training may give them a more nuanced understanding of the specific risks related to different classes of drugs for potential for abusive and neglectful parenting. Parents who use drugs for legitimate medical conditions may need information from their GP about how the drug may affect cognitive functioning and plan for parental respite or other support when using prescription drugs over an extended period of time.

3.4 *Investing time to develop the professional network*

Where enough time, effort, diplomacy and 'even humility' is invested, collaboration can be effective, "It's all about rapport, with [child protection] as much as with the client" p. 5 (Coates, 2017). More supportive connections are needed between parents, child protection and adult mental health (Jeffreys et al., 2011) and this could be promoted through community networks, professional development meetings and conferences to help collaboration and by inviting other organisations to participate in or host training to help foster links (A. Reupert & Maybery, 2008). Practice needs to be extended to other professional disciplines beyond the mental health sector (Power et al., 2015), for example, families may be receiving family therapy or counselling where the main presenting problem is not mental health problems. Family therapists can have relevant experience and skills to share with child protection and mental health workers. Identifying parents' 'emotional readiness' and the 'emotional safety' of children, and gaining consent to discuss parental mental problems would be familiar to family therapists and many have developed appropriate knowledge, language and confidence in talking about mental health problems with families (Power et al., 2015).

3.5 *Practice style and consistency of processes*

Different professions adopt different approaches when working with individuals and families where parental mental health and/or substance use problems are present. Adopting a non-confrontational and non-adversarial approach with families is important (Jeffreys et al.,

2011). Families are not always asked about how it feels raising a child or living as a child with a parent experiencing mental health problems, and this may relate to assumptions that professionals hold about parental mental health problems and parental capacity (Bibou-Nikou, 2003). Duffy and colleagues proposed a recovery approach which may offer an alternative in the interface between child protection and adult mental health (Duffy et al., 2016) where existing responses tend to be risk avoidant and over managerial (Munro, 2010). Coates recommends working towards consistency in processes and expectations (Coates, 2017).

3.6 *Building confidence*

Some professionals from different disciplines may lack confidence to work with family members outside their traditional service user interface. Those who do demonstrate skill and knowledge about family work, and can assess the degree of parental insight into a child's connection to other family members, are important predictors of positive family focused practice (Maybery et al., 2016). Experience from professionals beyond mental health settings could help develop appropriate knowledge, language and confidence in talking about parental mental health problems with families (Power et al., 2015). Staff also need confidence in the quality and availability of services as they are often inadequate to meet the needs of families and parenting stresses may be exacerbated by lack of adequate and appropriate support (Darlington et al., 2005b).

3.7 *Building in time*

Factoring in enough time to engage with clients on parenting issues is very important (Maybery et al., 2016; Maybery & Reupert, 2006; Slack & Webber, 2008). Time required to engage in family focused practice should be sanctioned, planned and accommodated by staff and their managers. Home visits should be enabled to develop family focused practice, and the opportunity to work with parents over a long period of time (Grant & Reupert, 2016). Smaller caseloads may lead to better family focused practice (Jeffreys et al., 2011). Timely access to treatment is crucial (Huebner et al., 2017). Waiting can promote a sense of hopelessness in parents (Altman, 2008) and early, extended treatment promotes better outcomes and children are reunified more quickly. Routine home visits may not be possible within Community Mental Health and Community Addictions Teams' workloads but this prevents obvious and important chances to engage with other family members and identify opportunities to offer support within the home setting.

3.8 *Assessing parental capacity*

Assessing parental capacity is rarely straightforward (Aldridge, 2006) and the process of doing so can communicate to parents that they aren't good enough (Göpfert, Webster, & Seeman, 1996). Mandatory reporting may compromise the professional's role and the use of risk-assessment checklists can limit practice relying on predefined questions that can be narrow in focus. Whilst risk assessment is necessary, it is important not to rely entirely on this and not discuss and manage risk (Gillingham & Bromfield, 2008). Not all parents are at risk, and risk is not always an active concern (Boursnell, 2014), "If parents access services then workers should view such opportunities as critical windows where support can in effect change the illness experience of these families by providing them with confidence in services 'rather than battles'" (Warin, 2009, p. 103). Managing risk together in effective collaborative working, and the way risk is managed may be key to effective collaboration (Coates, 2017). When collaboration between families and child protection is not working well, mental health and substance use professionals are in the important position of trying to strengthen collaboration by educating both the families and child protection professionals. "It is crucial that Mental Health/Drug & Alcohol clinicians work towards improving that relationship, rather than colluding with either party." (Coates, 2017, p. 7). Darlington recommends the integration of mental health assessment information into the assessment of parenting capacity (Darlington et al., 2005b). Assessing parenting capacity is difficult for all workers – some mental health workers don't think it is their role and child protection workers can feel their knowledge of mental health is insufficient (Darlington et al., 2005b).

3.9 *Offering practical support*

The Association of Directors of Children's Services recommends a 'no wrong doors' approach. Family members (including children) may be more willing to be involved in treatment if practical considerations are given to facilitate treatment. Transport (Huebner et al., 2017), proximity of services, age-appropriateness of services for children and for those providing temporary care e.g. foster parents (Bibou-Nikou, 2003) and meeting childcare costs to attend treatment (Alakus et al., 2007) can all help treatment adherence. Meeting places for children and adults should be child-friendly, Family Rooms should offer a "metaphorical welcome mat" (Isobel, Foster, & Edwards, 2015, p. 7) and should be considered a necessity not a luxury. Isobel recommends that Family Rooms in in-patient settings should be labelled, have high visibility and be in close proximity to the nursing station. A written policy for the use of the room should also be developed.

Family needs can range from food/shelter/transport, mental and physical health treatment, to more specific needs. Parents might need help finding employment, help with household chores and managing their finances. Families that have been socially isolated will also need

help identifying recreation and respite opportunities, dealing with partners and other family members, and negotiating with school personnel to meet children's needs. Schedule home visits in the window after school so children will be at home (Cooklin, 2013). Biebel's *Family Options* model also developed flexible funding arrangements that could quickly help families under financial pressure. Experience of the Family Coaches in Biebel's research found they had to modify their approach from 'fixing' problems to empowering families to problem solve on their own (Biebel et al., 2014).

Most of the parents interviewed by Boursnell, required additional support including practical help at home. Many felt that if there was more support available, parents may feel more confident to access it instead of just trying to cope (Boursnell, 2014). Beyond the practical suggestions made to facilitate treatment adherence, Finkelstein describes other initiatives that helped to develop commitment to programme attendance in a child-focused intervention including a craft group for mothers, providing a family meal after group meetings, parenting skills, child care (Finkelstein et al., 2005). Alakus suggests that getting a diagnosis can restrict parents' independence and damage their confidence. This led to the development of a 'Collaborative Treatment Journal', a small pocket journal held by the consumer for recording appointment times, important telephone numbers and healthcare plans and was designed to increase the service user's control over events that could impact on their mental health and children (Alakus et al., 2007). The authors of this report are currently involved in exploring how families can be more effectively supported to navigate the complexities of the wide range of professionals and organisations they may have contact with (see Davidson for further details).

3.10 *The role of other agencies/care providers*

General practice/routine paediatric check-ups

Many parents experiencing mental health problems who do seek help, go to their GP. GPs can play a role talking to parents about their mental health (Baulderstone, Morgan, & Fudge, 2013). Other techniques include the useful tool of the genogram which can be developed over several visits, evolving the therapeutic relationship and which looks at all elements of the family including deceased children, step children, miscarriages, previous partners and close family supports. Baulderstone also promotes the opportunity for GPs to explore parenting achievements and to talk with children about parental mental health using age appropriate language and that is emotionally suitable. GPs can signpost older children to peer support and online help as well as identifying risks during perinatal period (Baulderstone et al., 2013).

Gulbra's work in Norway, explores recognising children as next of kin in GP surgeries (Gullbra, Smith-Sivertsen, Rortveit, Anderssen, & Hafting, 2014). Many examples of how to help

children were explored in qualitative focus groups with GPs (N=27). These included: identifying children at risk, counselling parents and supporting their parenting role; and taking part in collaboration with other healthcare professionals and social workers. Barriers were also identified: time constraints, short consultations; a main focus on the patient (parent) in consultation and where children are often outside the attention of doctors; GPs afraid of hurting or losing their vulnerable patients and may avoid bringing up the child for discussion.

“Pediatric primary care providers are poised to lay a critical role in prevention, education, screening, and referral of families at risk of parental opioid addiction” (Spehr, Coddington, Ahmed, & Jones, 2017, p. 5). Providers should approach parents in an empathetic non-judgemental way to promote trust and paediatric care providers must be prepared to care for children affected by parental opioid use including those exposed in utero. For children exposed at home, Spehr and colleagues recommend that: children are assessed in respect of parental substance use at each child check-up; mothers are encouraged to continue to breastfeed; parents are educated about safety plans, postpartum depression, treatment options, and safe sleep; children at risk be should be referred to counselling and social services; professionals should understand the relevant legislation on reporting to child protection services; and, should always report to child protection services if child abuse and/or neglect is suspected.

Family therapists

In Somerset Partnership NHS and Social Care Trust, family therapists were used to providing training in attitudes and skills (Stanbridge & Burbach, 2007). Stanbridge and Burbach suggest that family therapists may need to seek wider organisational roles to work in partnership with colleagues who are developing services for carers and influence management systems. Family therapists could also contribute to the routine supervision of staff to help develop a systemic approach which could be helpful in the broader context.

Schools

A number of authors have stressed the importance of engaging schools in both supporting and treating students within a safe and secure setting (Association of Directors of Children's Services; Biebel et al., 2014; Contractor et al., 2012; Cooklin, 2013). Cooklin suggests that mental health workers could offer support to local school projects by giving advice and/or attend groups to answer general questions (Cooklin, 2013).

The community

Community awareness and support for parents is limited (Alakus et al., 2007; Cremers et al., 2014) and a better understanding of the actual needs of the local population is needed

(Association of Directors of Children's Services). It is important to have appropriate resources locally and to identify and nurture new relationships, or invigorate existing partnerships to leverage co-ordinated services for families. Existing community resources can be used to fill and bridge gaps to avoid duplicating services in an attempt to integrate the services (Biebel et al., 2016). Nicholson's evaluation of existing adult mental health provision highlighted the need to educate and advocate with school personnel, child welfare workers, lawyers, judges, primary care physicians and landlords about mental illness to facilitate successful outcomes for families and develop important community collaboration (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007). Huebner concluded that there is a lack of co-ordination between child welfare and other services/systems including hospitals that may screen for drug exposure, treatment agencies, mental health services, criminal justice system and family/dependency courses (Huebner et al., 2017). Adult psychiatry should assess the situation of all family members including children (Pölkki et al., 2005).

3.11 *Resources*

Pressure on resources is stressed repeatedly in the literature and has a direct impact on interagency collaboration (Alakus et al., 2007; Baistow & Hetherington, 2004; Darlington et al., 2005b) with demands from staff shortages, heavy workloads and high staff turnover (Alakus et al., 2007; Aldridge, 2006; Contractor et al., 2012). For example, although very positive developments are being seen in Australian practice, the sustainability of organisational change has been the biggest challenge with high staff turnover and two thirds of staff posts vacant in New South Wales (Falkov, 2016). Existing mental health services may have limited capacity and expertise to meet need (Biebel et al., 2014; Maybery et al., 2016). Adult mental health workers reported time and resource limitations, skill and knowledge deficits regarding parenting and working with children (Maybery & Reupert, 2006). Resource inadequacies were also identified as a problem trying to implement new systems to improve interagency collaboration in Clark and Smith's research (Clark & Smith, 2009). In substance use treatment, Huebner found that there were inadequate funds for services and/or depended on client insurance coverage which compromised treatment (Huebner et al., 2017).

Social workers should have access to high quality, flexible administrative support – described as 'trouble shooters who can get things done for families' (Oxford Brookes University Institute of Public Care, 2015). Data collection varies from agency to agency, and often information is not shared between systems. Better data administration and co-ordination is necessary which could streamline paperwork to 'one child – one chart' model (Conners, Bokony, Whiteside-Mansell, Bradley, & Liu, 2004) and mean that families do not have to repeat their (often distressing) history.

3.12 Models of best practice

General features of interventions that work for families include well-supported staff, who are innovative and when necessary can take decisive action rather than confined to assessing and monitoring family outcomes. Tools and practice to enable delivery should have a shared theory of practice, deliver evidence-based work and have the skills to engage children with an appropriate level of supervision/team meetings to encourage critical reflection and theory development (Oxford Brookes University Institute of Public Care, 2015). It is also recommended that the workforce is structured to provide intensive support to the most vulnerable families, with inter-disciplinary teams and/or social workers that have easy access to clinical support. Teams should be small with a flattish structure, with staff that are well trained in the organisation's practice and theory and evidence-based practice techniques. Managers should be involved in direct work and be capable of providing mentoring and support. Teams should share collective responsibility for cases and caseloads with caseloads for key workers to be no more than 10-12. Staff retention can be a problem therefore it is important that career paths should be available within the organisation.

3.13 Further evaluation and research

Further evidence is required (Jeffreys et al., 2011). Very few programmes have established critical evaluations of their effectiveness (Darlington et al., 2005b; Reupert & Maybery, 2009, 2010) and there has been a call for more evidence-based training and best practice models to be shared (Oxford Brookes University Institute of Public Care, 2015; Power et al., 2015). New services should be developed, piloted and evaluated to support families with complex needs with more integrated models of service development (Darlington et al., 2005b) and services with a greater emphasis on innovative and prevention programmes (Contractor et al., 2012; Huebner et al., 2017). Secondary prevention services should be strengthened to improve staff capacity (training, supervision and support), giving staff greater opportunities for workers to review and critically reflect on their assessment processes and outcomes (Darlington et al., 2010). Reupert conducted qualitative analysis to identify research priority areas, of the n=144 professionals responding, the key areas for focus were: service orientation; interventions; risk and protective factors; parent, child and family feedback and involvement; stigma; research and access (Reupert et al., 2016). More qualitative work is required to document families' stories (Foster et al., 2016). There is a need for further theory development to encourage inter-disciplinary and inter-agency collaboration (Foster et al., 2016; Oxford Brookes University Institute of Public Care, 2015) and greater knowledge about how the age of the child impacts on effects and interventions.

3.14 *More and better quality data*

More data is needed (Boursnell, 2014). Service users would benefit if more information was collected about their children, identifying their needs and providing a basis for prevention and early intervention work. Data could be used to help identify risk factors for social isolation. Assessment mechanisms should be integrated so families don't have to keep repeating their stories (Association of Directors of Children's Services). Services continue to operate with standardised measures which fail to draw out family strengths but demonstrate service effectiveness and allow statistical reporting (Boursnell, 2014) and integrated ways of measuring outcomes (Foster et al., 2016). Dore recommends embedding screening questionnaires in routine data collection and administered by caseworkers with interview skills (Dore et al., 1995). Screening should not just be applied to the parent, but all family members. Asking about family histories of addiction is important, a three-generation genogram can help put their own mental health or substance use issues into an intergenerational context and may motivate parents to seek treatment. Substance use is often associated with other factors e.g. depression, early sexual abuse, which have important implications for treatment planning. There are some good examples of integrated data collection systems to aid delivery of family focused practice; in the START programme data was used to monitor and motivate efforts of treatment fidelity and promote understanding of parent and child needs (Huebner et al., 2017). New international research is currently underway led by Darryl Maybery at Monash University to develop a common set of outcome measures that could be routinely used across services.

Section 4: Think Family (NI)

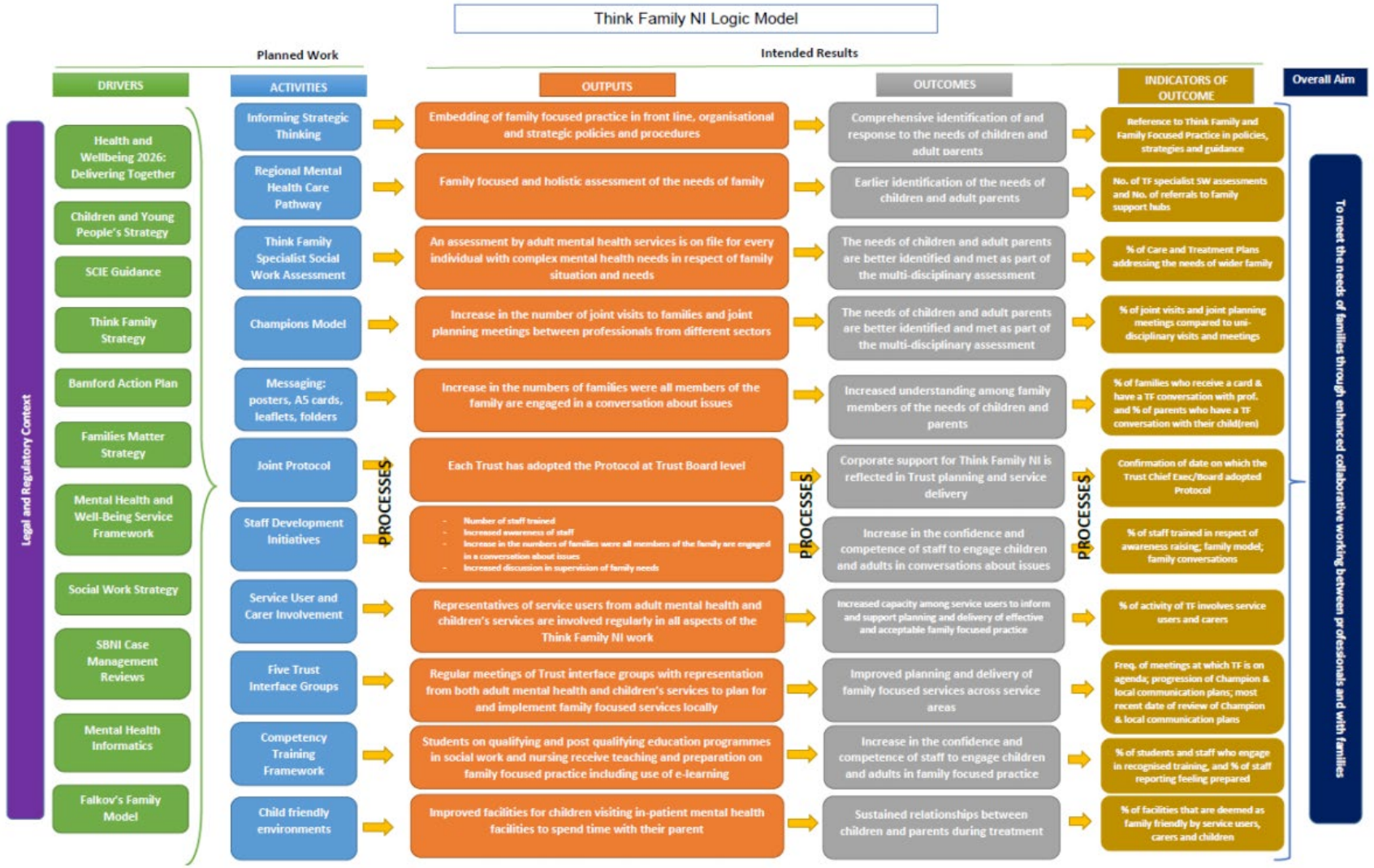
The Think Family (NI) Project was established in 2009 by the Health and Social Care Board in Northern Ireland and over the last ten years a range of initiatives have been introduced to promote health and social care professionals' response to families where parental mental ill health is present. Influenced by SCIE's 'Think Child, Think Parent, Think Family' work (Social Care Institute for Excellence, 2011), Dr Adrian Falkov's commissioned consultation and The Family Model (TFM) (Adrian Falkov, 2012) has been the main theoretical basis for more recent developments. This work included the development of an 'Adult and Children's Services Joint Protocol for Responding to the Needs of Children whose Parents have Mental Health and/or Substance Misuse Issues' (Health and Social Care Board, 2011) which sought to help parents understand their mental health issues. It also considered their treatment plan and the impact their mental ill health could have on their parenting and their relationship with their child. The Think Family NI Logic Model was developed to provide an overview of the developments, in Northern Ireland, the processes of change and the intended outcomes (See Figure 1 on the next page).

Current level of need in Northern Ireland

In March 2019, 24,289 children were designated as 'in need' in Northern Ireland, of these, 2,211 were on the child protection register, and 3,281 children were looked after. In 2018-19, 1,106 adults were detained at admission under the Mental Health (NI) Order (voluntary patients are not included in this number). On 30th April, 6,743 persons were reported to be in treatment for their use of alcohol and/or drugs. Belfast HSCT has the highest proportion in treatment (29.3%, 1,975 clients). Statutory services contained the majority of clients in treatment (58.9%, 3,971 clients) followed by non-statutory service providers (37.8%, 2,550 clients) and prison based services (3.3%, 222 clients). As with previous years the largest proportion of clients were receiving treatment for alcohol misuse only (38.0%, 2,560 clients); followed by around one-third for drugs misuse only (32.6%, 2,201 clients); and just under one-third of clients for both alcohol and drugs misuse (29.4%, 1,982 clients). In 2019, two-thirds of clients in treatment (66.3%, 4,470 clients) were male, and one-third were female (33.7%, 2,273 clients). This was similar to the proportions seen in previous census.

The majority of clients in Northern Ireland (95%) received non-residential treatment. The remaining 5% of clients were split between residential treatment (4.8%, 323 clients) and mixed services which provided both residential and non-residential treatment (0.2%, 13 clients).

Figure 1: *Think Family NI Logic Model*



4.1 Aims and objectives

The Health and Social Care Board commissioned an audit of case files from across mental health, addictions and children's services teams to establish whether Think Family NI and family focused practice has become embedded across the different services. This was an audit of a random sample of case files from across three different services (Adult Mental Health, Community Addictions, Children's Services) in the Health and Social Care Trusts in Northern Ireland. One of the five Trusts declined to participate because of current workforce pressures. The role and remit of each of the three services is different but overlapping, and there are some variations in how these services are structured between and within the Trusts. In general, adult mental health services are secondary level services which receive most of their referrals from primary care and from within secondary services. Adult mental health services tend to be organised in generic Community Mental Health Teams or split into more Primary Care oriented (with a focus on common mental health problems) and Recovery/Rehabilitation oriented (with a focus on severe and enduring mental health problems) teams. Community Addictions services are also specialist community services with a focus on interventions to support people who are using alcohol and/or other drugs in a harmful or problematic way. They also receive most of their referrals from primary care and secondary mental health services. Children's services in the Trusts are focused on promoting and protecting the welfare of children and families. They tend to be organised into initial assessment or Gateway Teams, which receive referrals from any source and provide an initial response, and, if further intervention is necessary, refer to the Family Intervention Teams.

4.2 Methods: sampling, audit measures

Administration teams in each Trust were asked to sample 30 files (10 from each service; total N = 120 files) that met the following criteria:

- a case file that had been open within the last 12 months;
- with a mental health and/or substance misuse problems that have had or are having; a significant and enduring impact on social and personal functioning;
- past or present support from Community Mental Health/Addictions; and
- past or present support from Children and Family Services.

Teams represented in the case files included: CAMHS, Children's Disability, Family Intervention, Family Support, Community MH Early Intervention, Community Forensic Mental Health, Community MH Recovery and Community Addictions.

The audit tool was developed to reflect the key domains within the Joint Protocol. Ethical approval was not required however a stringent process included an application to the Assistant

Directors of Social Work and approval from Research Governance within each participating HSC Trust. The data was processed under Article 6 GDPR, 1(e) (the legal basis was in the legitimate interests of the data controller and third party (QUB) resulting in an improved service for clients). Both electronic records and paper files were made available to the researcher where possible. Data collection was conducted onsite in locations across Northern Ireland and temporary permission granted to access online files in accordance with the approved Research Governance procedures. Trusts provided a quiet workspace in each setting and staff were available to clarify any queries the researcher raised. Data were collected on an encrypted laptop, then securely transferred to the university network at the end of each data collection session. Case file data formats and processes varied considerably between Trusts and services.

Audit measures

Each case file was pseudonymised at point of data collection. Demographic information was captured including gender, HSCT, age category, disability, number/age/disability of children. Postcodes were converted to Super Output Area at source to provide a proxy measure of deprivation. The primary service was recorded, along with key worker discipline where available. More detailed information was collected about parenting difficulties, contact with other agencies and the action that had been taken to support the family. A checklist of Think Family specific information was also included to indicate whether the mental health issue had been explained to the parent and child, the impact on parenting, pregnancy or caring responsibilities of the child(ren). Evidence of completed UNOCINI referrals or pathways, parental and child involvement in the screening/assessment and care planning process and the Think Family NI resources/approach had been referenced in the files. Finally, any further evidence of family focused practice such as meetings with the family, psychoeducation and FF conversations were recorded. Finally, evidence of interagency contact was examined – including email, letter and telephone call records held in the files. The Coronavirus lock down ended fieldwork and additional electronic data from some files were unavailable (N=12) and have not been included in the analysis. A copy of the audit tool is included as an appendix (Appendix 1).

4.3 *Results*

Data are presented from 108 of the 120 available files. Of the 108 files, ten were linked during data collection and analysed as a family unit (five files from adult services matched with five Children's Services files) and a total of 103 families.

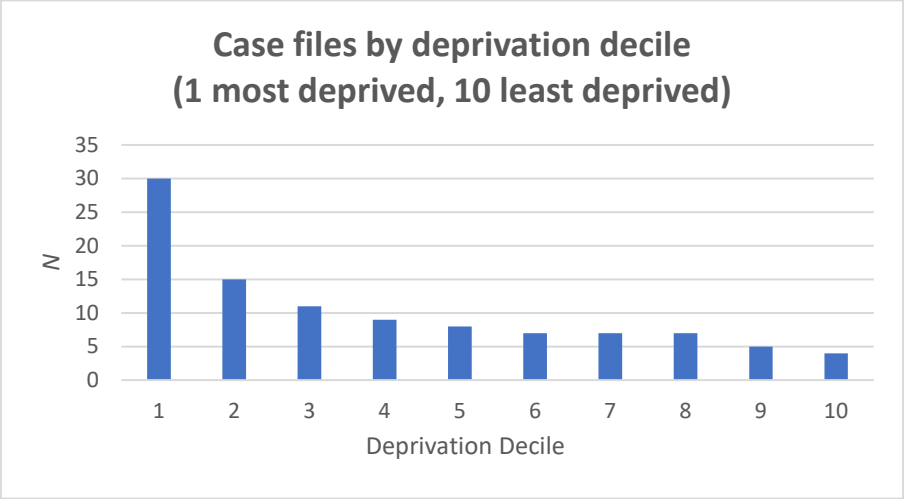
Demographic profile of case files

Of the 103 families (*N* = 258 children and 6 pregnancies), the majority of case files focused on mothers (*N* = 85, 82.5%) rather than fathers (*N* = 18, 17.5%). Cases were representative across the three services: Children's (*N* = 29, 28.2%); Community Addictions (*N* = 39, 37.9%); and Community Mental Health (*N* = 35, 34.0%). (There is a slightly lower number of Children's Services cases because the parent file in the 10 matched cases was treated as the primary case for analysis.)

Deprivation

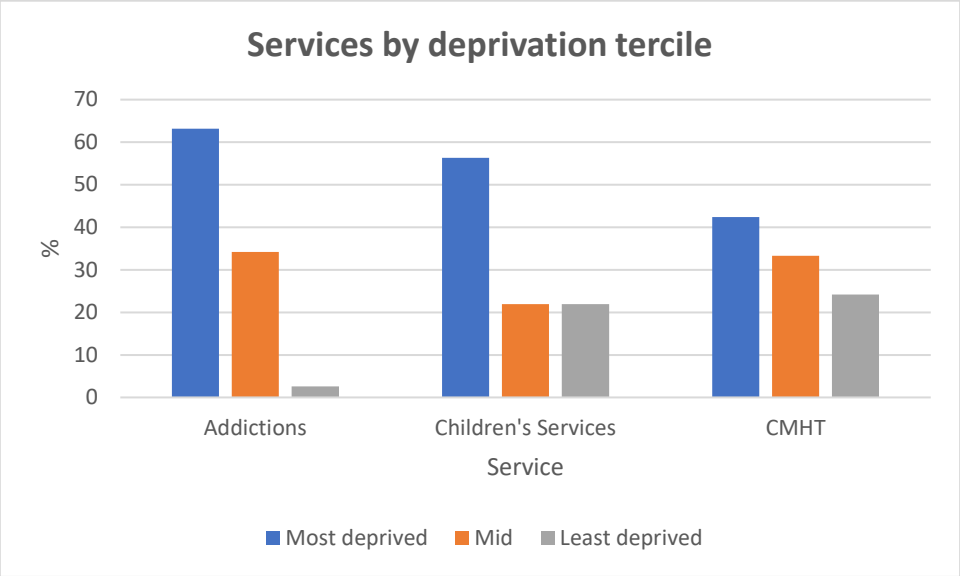
As expected, there was a greater proportion of families living in higher area-level deprivation in the sampled case files. Almost one third of cases (27.2%) were located in the most deprived decile, seven times higher than the least deprived decile (3.9%).

Figure 2: Case files by deprivation decile (1 most deprived, 10 least deprived)



The type of service the family was involved with also reflected a social gradient. Parents receiving Addiction Services were more likely to be located in areas of higher deprivation compared to Children's and CMHT.

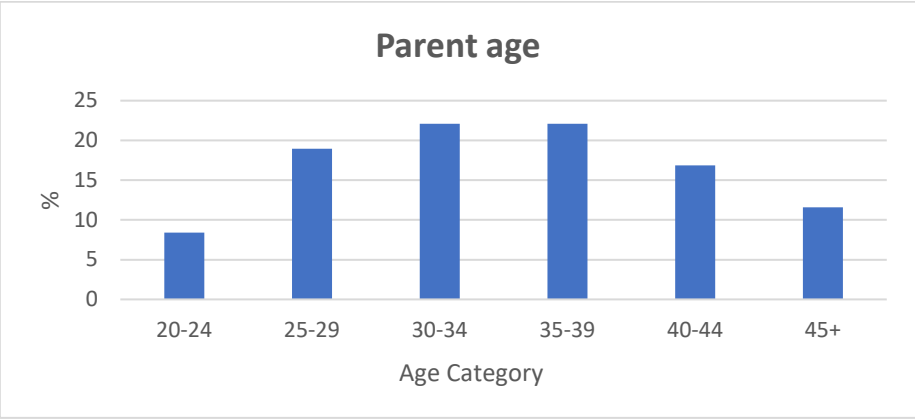
Figure 3: Services by deprivation tercile



Age

Most parents were aged between 30-39 years old, and the age categories ranged from 20 to 54 years. Parent age was evenly distributed across all age categories in the Children's Services files, but the mean age category in Addictions was 30-34 years (28.2%) and in Community Mental Health files, parents tended to be a little older (25.7% aged 35-39 years).

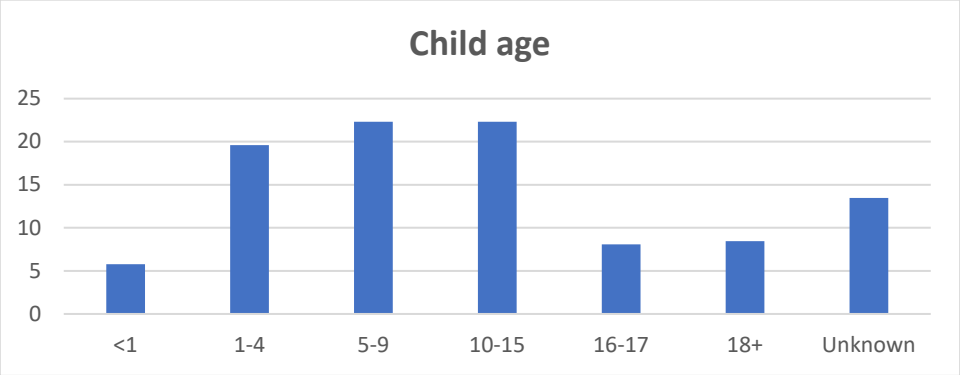
Figure 4: Parent age



The majority of children were aged between under 16 years. In 10 files, no child ages were recorded (2 files from Children's; 5 from Addictions; and 3 from CMHTs). Parents in receipt of Community Mental Health Services were more likely to have younger children (26% were aged 1-4 years). Addictions had an even split between younger (1-4 years, 25.6%) and older children (10-14, 26%). Children's Services files were more likely to involve 10-14 year olds (27%) than any other age group. Both Addictions and CMHT were supporting parents with

very young children (aged 1-4 years). We do not know how representative these case files are however it does have implications for how messages and conversations take place with different aged children and how confident staff are communicating these. Communicating effectively with children can be challenging and talking with young children versus adolescents requires differing knowledge and skill sets that may not be included in routine training within mental health services compared to child and family work.

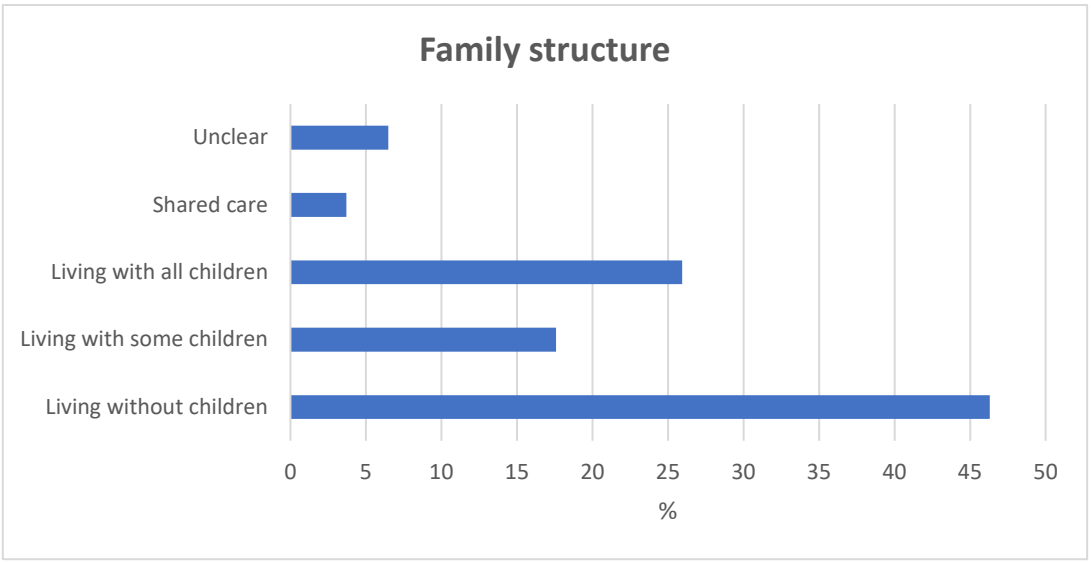
Figure 5: Child age



Family structure

Just over one quarter of families (26%) were living together with all their children, and 17% were living with some of their children. However, the vast majority of families were not living with their family intact, with over 45% of parents living without any children (this doesn't include those with children aged over 18 who may have left home). A small number of families had a shared care arrangement between mother and father but in 6.5% of cases, it was unclear where the child(ren) resided or who had parental responsibility for them.

Figure 6: Family structure

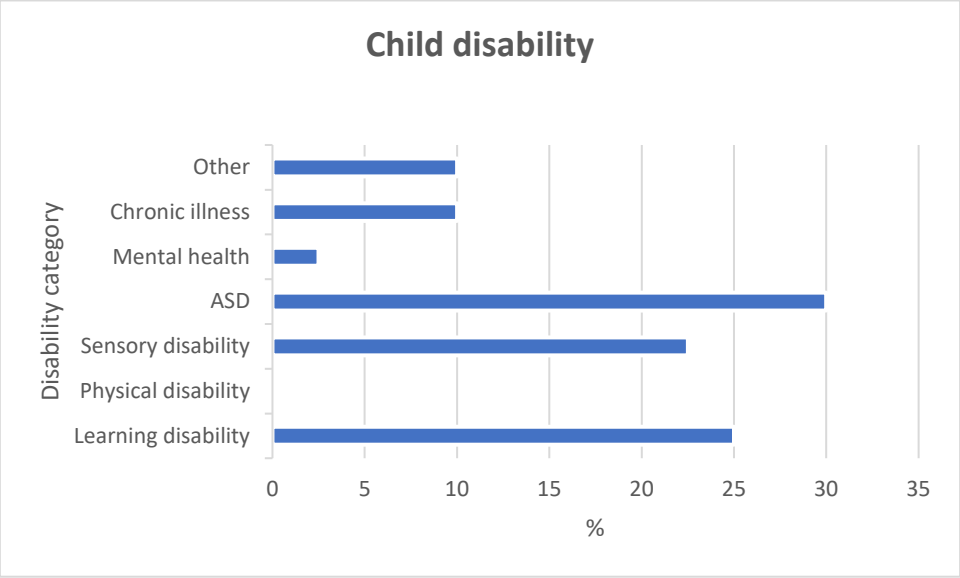


The majority of families had one (27.5%), two (27.5%), or three (27.5%) children. However, 18 families had four or more children.

Disability

Ten per cent of families (N=26) had a child with a disability (13% of all children), and seven families were living with two or more children with additional needs. Autistic Spectrum Disorder (ASD) was the most commonly reported disability. No children reported a physical disability in the sampled files. The number of parents with a reported disability (other than mental health) was too small to report.

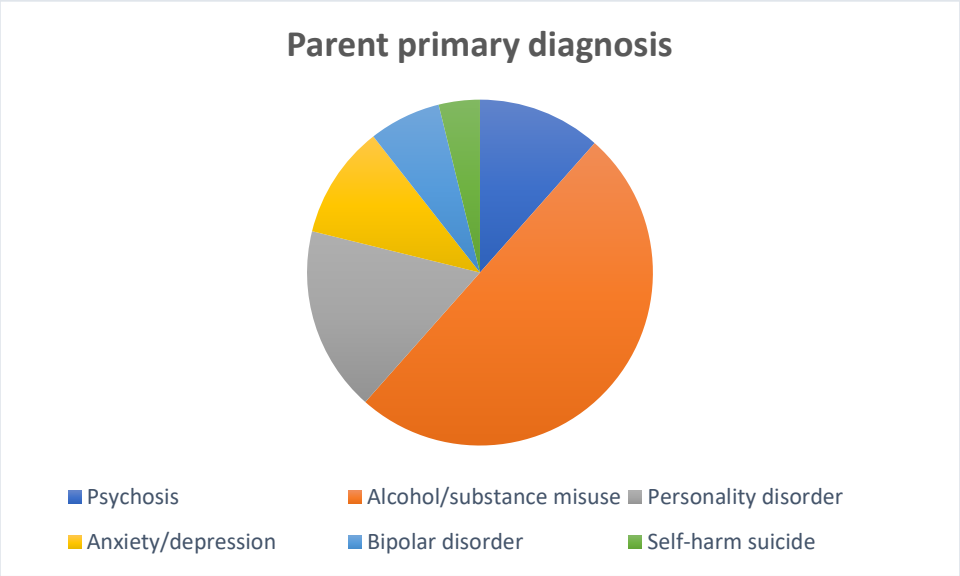
Figure 7: Child disability



Complexity of cases

Many of the families had been supported by social services for some time, the average length of involvement was over 6 years (*M* = 6.2 years, *SD* = 5.71, range 3 months to 28 years). Cases were complex, with most parents having significant co-morbidities and experiences of trauma. Only 23 cases reported a single mental health or substance use condition.

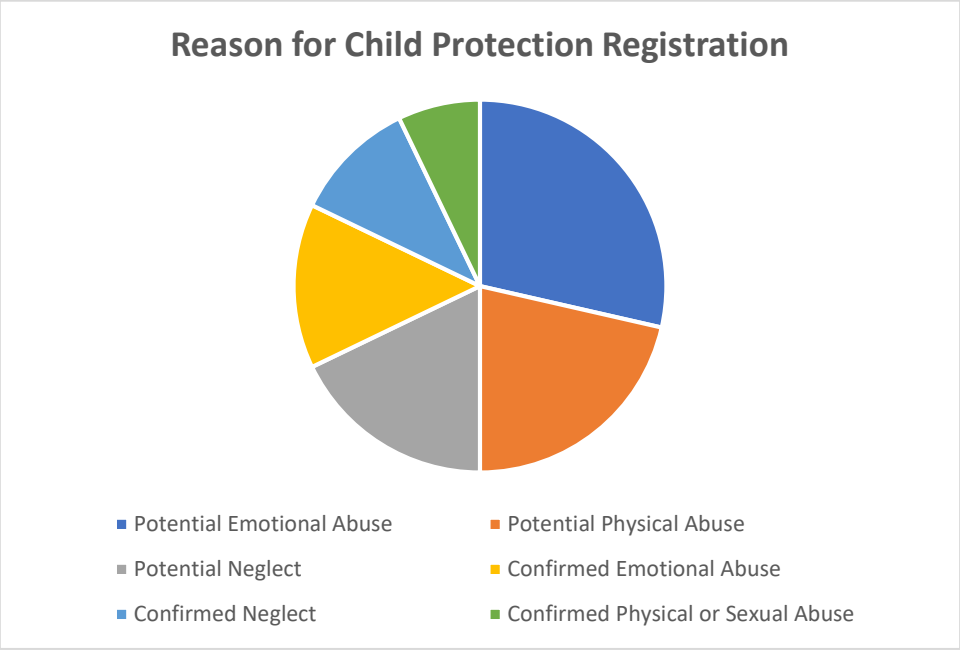
Figure 8: Parent primary diagnosis



Alcohol and substance misuse were the largest diagnostic category, followed by personality disorder and psychosis. Common comorbidities included anxiety and/or depression, chronic pain, problematic alcohol/substance use and psychosis; many parents had also experiences of child sexual abuse, domestic violence or care histories. It was reported in the case files that half of parents also had thoughts of life not worth living, suicide ideation and/or episodes of deliberate self-harm.

Child Protection Registration was recorded in 78 case files and 50 cases also had involvement with looked after teams. The most common reason for registration was potential emotional abuse, closely followed by potential physical abuse.

Figure 9: Reason for Child Protection Registration



Workforce profile

Addictions Services staff had a more diverse professional profile than Children's Services who were exclusively social work practitioners. One third were social workers, a further ten were Mental Health Nurses, Community Psychiatric Nurses or Drug Outreach Workers, but in 15 case files, there was no information in the file to identify which profession the key worker was from Community Mental Health Teams were largely drawn from social work (N=25) but nine staff were Mental Health Nurses or Community Psychiatric Nurses.

Evidence of family focused practice

The audit captured data based on the use of the 'Adult and Children's Services Joint Protocol – responding to the needs of children whose parents have mental health and/or substance misuse issues' and looked for evidence of family focused practice in case notes, notes of telephone calls or emails or face-to-face conversations recorded in the files.

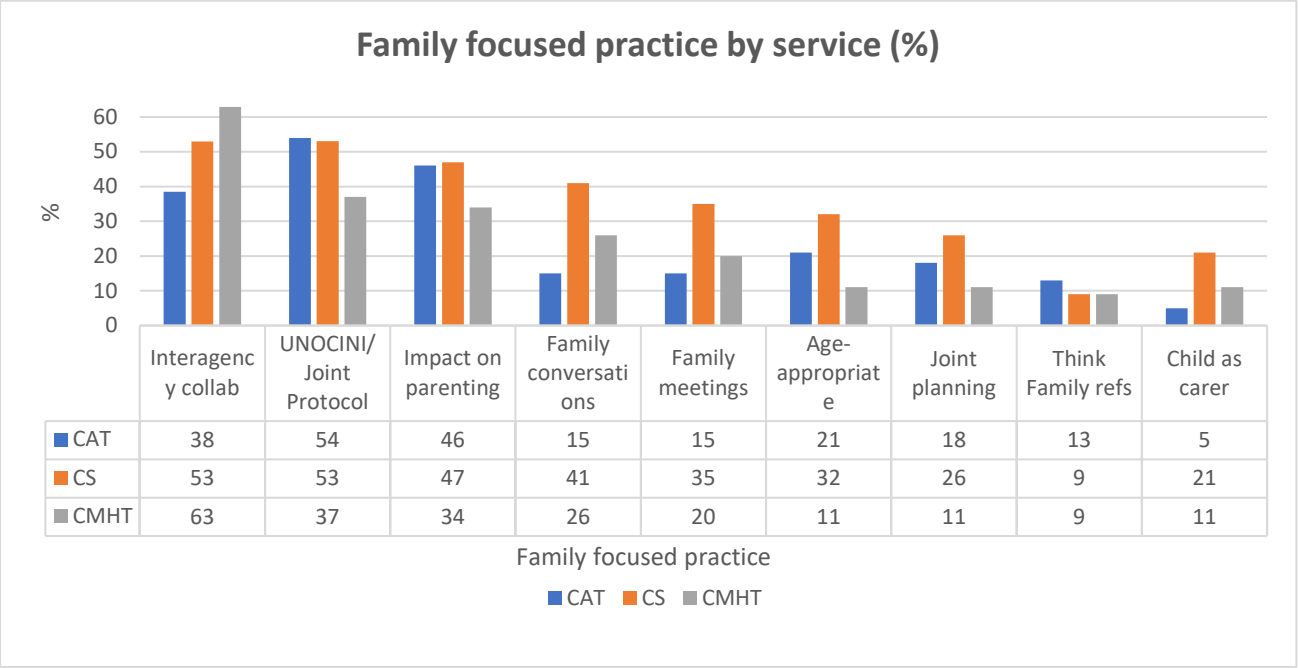
Table 1: Case file evidence of family focused practice

Case file evidence of family focused practice	N	%
Interagency collaboration	55	53.4
UNOCINI/Joint Protocol in file (49/3)	52	50.5
Explaining the impact of mental health on parenting	46	44.7
Family conversations	29	28.2
Family meetings	25	24.3
Age-appropriate explanations to children	23	22.3
Joint care planning	19	18.5
References to Think Family/Hidden Harm work	18	17.5
Child's caring responsibilities discussed	13	12.6
Think Family resources in file	3	2.9

Practice differences across the three services

It is encouraging that over half of the files examined demonstrated evidence of interagency collaboration but it is clear that more work is required to promote and encourage joint working of cases. Files from Community Mental Health Teams were more likely to demonstrate interagency working that either Children's Services or Addictions. Alignment of procedures across services appear to have some level of integration with many files including UNOCINI assessments of the child(ren)'s needs, but very few files had a copy of the Joint Protocol (N=3). This of course does not mean that these tools are not being used in practice, but they do not seem to be routinely included in case records.

Figure 10: Family focused practice by service (%)



Many practitioners recorded details of having meetings with families and described different ways of encouraging family conversations. Children's Services social workers were more familiar with engaging with children on a one-to-one basis and recording conventions in the case notes files always included a section that detailed individual conversations with the child where appropriate. This was not routine in Addictions or CMHT.

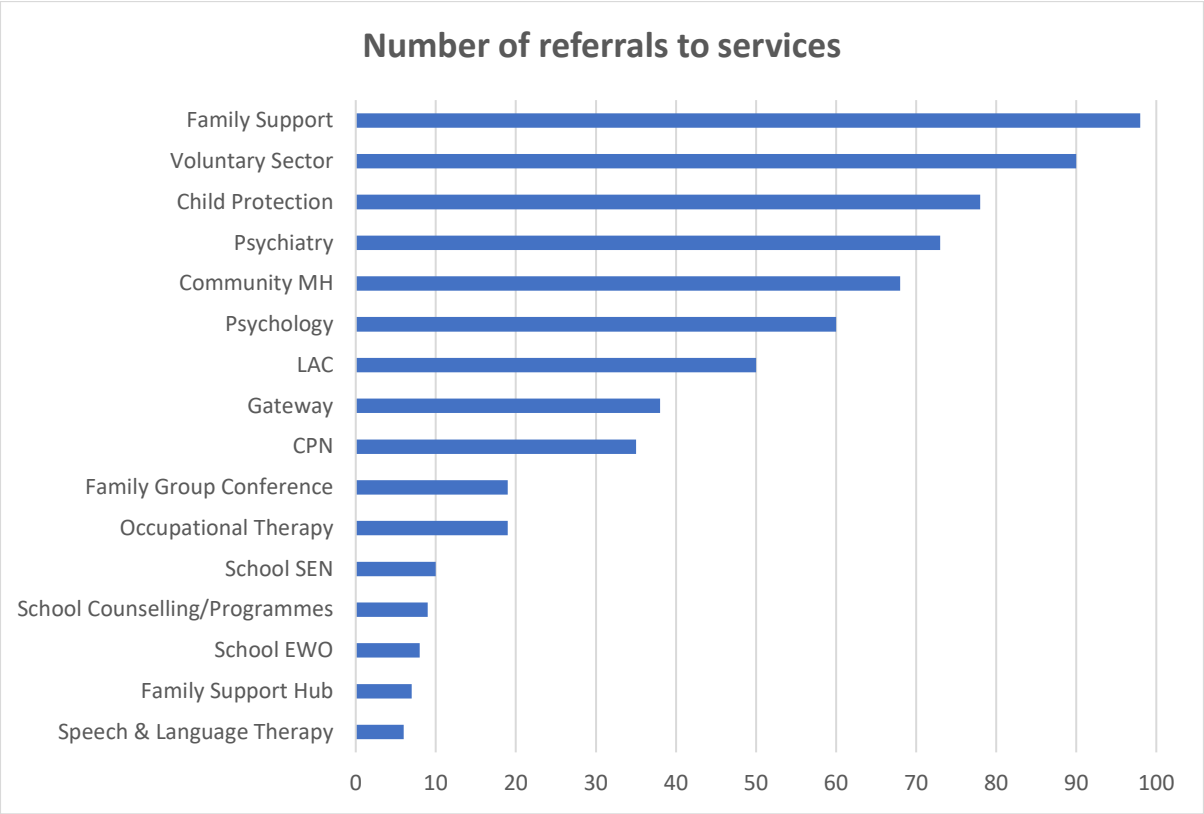
Looking at the different emphasis in practise between the three services, Children's Services reported more direct engagement with children. They were more likely to discuss the role of the child as carer, present age-appropriate conversations with children and demonstrated evidence of promoting family conversations and meetings. This also has to be seen in the context of the older age group of Children's Services files, it is probably much easier to have a conversation with a 10-14 year old and detail how this has gone with an older child compared to one much younger (aged 1-4).

Common referrals

Families were most likely to have some kind of support from a Family Intervention or Family Support Team which could include child protection and LAC teams. The voluntary sector was a large source of help and this include statutory provision delivered through voluntary agencies such as Barnardo's, Extern and Start 360 as some examples. Many families also received referrals to psychiatric or psychological services and this included inpatient treatment for some. A number of children received additional support within the school setting and this could

include literacy and numeracy support, school based counselling services and Education Welfare. Referrals to the Family Support Hubs was relatively small but previous or self-referrals may not have been included in formal case notes.

Figure 11: Number of referrals to services



Complexity of service delivery

The audit searched files for referrals and delivery of interventions during the previous five-year period. The average number of referrals per family was 11 (*M* = 11.0, *SD* = 5.21; range 2 to 26). Of these referrals, families engaged with an average of 9.2 services, (*M* = 9.21, *SD* = 4.94; range 1 to 23).

4.4 *Qualitative themes*

There was short section within the Audit Tool to capture qualitative information where relevant and appropriate.

The number of referrals and services involved can feel overwhelming

On average, nine different agencies were involved with each family. Although this support was aimed at helping the family, it will have required planning, co-ordination, time and other

resources. This needs to be considered within the context of other pressures relating to a parent's mental health or substance misuse issues and many of the routine challenges associated with parenting. There were examples of parents who had hidden literacy issues and struggled to maintain appointments or read correspondence. Parents not complying with certain appointments could be seen as disengaged and refusing treatment and this was not always the case. One mother had a good relationship with her CPN but declined support,

> "*because she felt that there were already too many agencies involved and this could have a negative impact on her mental state as she finds it very stressful*."
>
> (Addictions)

Building trust and honesty

This was an issue for some parents and could negatively impact on interactions with services. One client terminated an interview when the key worker wanted to complete a UNOCINI (Addictions). Another mother wanted her pregnancy terminated because she felt that social services would just remove the baby following the birth, she told her social worker that there was,

> "*No point in making plans for the baby as I will not be allowed to keep it.*"
>
> (CMHT)

Other parents reported that they either weren't aware they had been referred to Children's Services or didn't understand the reasons why (CMHT). The trust of a known professional and confidante could also be challenged when a second service became involved. One mother expressed unhappiness with the report prepared by CMHT for Children's Services, feeling that confidences had been broken. CMHT had to stress the importance of the child's safety. In another example, both parents discussed the difficulties they were having with their teenage son with their mental health social worker. They believed that he would benefit from talking to a professional but they were afraid to ask for a referral in case he was removed from their care.

Another mental health worker had to explain that the Children's Services social worker had,

> "*recommended that mum couldn't see her child until she gets better*"
>
> (CMHT)

Conversely, some professionals wanted to be honest and open with service users about the importance of working with the support available,

"*Someone needs to take the lead and have an honest conversation with both parents and prepare them for the potential inevitability of their child being taken into care.*"

(CMHT)

There was some empathy for parents from mental health staff, one professional noted that [mother],

"*has lots of reasonable concerns about social services involvement and is worried that her every move will be watched. I tried to reassure her that everybody is here to support her and we are all on her side…she finds it difficult to trust people and in my view all her concerns were understandable and reasonable.*"

(CMHT)

Understanding the complexity of mental health issues

As we have already outlined, the complexity of many mental health issues are considerable. Multiple co-morbidities require close monitoring of many cases, needing different medications and managing a range of symptoms that can have changing impact on day-to-day functioning. The importance of stabilising a parent's mental health in order to consider carrying out additional parenting assessments or other needs assessments was a strong message from CMHT and Addictions. There were examples of parents discussing problem behaviours or parenting issues with Children's Services, but no specific advice was offered about how to deal with issues. One case file reported that they,

"encouraged mum to implement rules and stick to them and to stop blaming the children"

(Children's Services)

On the other hand, some social workers were able to offer an insight into a parent's difficulties. After speaking to Children's Services, one mother felt much more confident to cancel contact if she was feeling unwell and that the social worker would understand (Children's Services). Another social worker recorded in the file that they had stepped back from the case for the rest of the day as they realised their presence was contributing to a mother's anger and distress (Children's Services).

One child protection file detailed the prosecution of a parent for their child's refusal to attend school. This led to an acute inpatient admission and the story unfolded of a significantly depressed adult who could not get out of bed to take their child to school. Undoubtedly a

prosecution could have been avoided if early contact had been made with the parent's mental health professional and appropriate support provided. Another Child and Family Social Worker spent time with a parent to talk through the case conference report were there was a lack of insight on the mother's part, and time taken to explain the detail was valued (Children's Services). Professionals also had difficulty making contact with individuals and they often used their contacts within the more trusted service (Addictions or CMHT) to encourage involvement. Some parents were also supported to re-enter the workplace as this was considered important to help recovery in some cases. Occupational therapy referrals were used where deemed appropriate. Understanding that some parents were not ready for therapeutic support was also recognised, one CMHT worker explained to Children's Services that the parent,

> *"is not currently stable enough for therapeutic interventions"*
>
> (CMHT)

Other parents were supported to have access as a realistic goal rather than have the children returned home. Workers provided advocacy and support and enabled one particular parent to be stable through medication and stress management during child protection court proceedings. The CMHT social worker clearly recognised how stressful this process was and the added anxiety was likely to exacerbate her mental health condition. Building community links was also an opportunity to support complicated cases to try and establish a network of support when parents were released from inpatient care.

Professional roles and boundaries

There were examples where workers didn't have any contact with the children. Part of the UNOCINI includes a question "are the children in the family aware that a referral is being made?" In one file, it was answered,

> *"No. I do not have direct access with the children and therefore have no access to them."*
>
> (Addictions)

Other parents weren't clear about the role of their key worker. One service user asked their Addictions social worker to contact the Family Intervention Team to advocate for school transport for their children. There were other cases where the professional expertise of another service was clearly requested. One example includes a request of Children's Services to a Drug Outreach worker to do some family work in relation to parent drinking.

The files worked by specialist social workers in addiction services (with a specific remit to work with families with parental substance use problems) were some of the best examples of family focused practice. One worker closely supported a mother to discuss the impact of her alcohol use on her parenting and help her to work towards controlled drinking. A safety plan was set in place if the mother wanted to drink but also sought to identify and help her to recognise the triggers for drinking. Another case described a teenage boy who wanted to understand more about his father's illness and his distress of not knowing what was going on at home. He knew his parents were trying to protect him and the illness was not something they discussed as a family. He wanted to be updated on his father's progress and meet the Consultant responsible for his parent's care. As a result his mother agreed to be more forthcoming and discuss his father's appointments. Her son felt reassured that it was ok to ask questions and to talk openly about mental illness. He also said he enjoyed talking about this and would like to talk further again. This was an example of a really positive relationship with the social worker and meaningful engagement with family.

Another social worker worked with a single parent living with the children; the other parent was living out of the family home and the relationship with the children had deteriorated badly. While the children didn't feel ready to see the absent parent, the social worker was able to offer advice and practical support to try and rebuild the relationship. This included identifying another family member who could help facilitate meeting in a neutral place and progress contact slowly at the children's pace. The continued support of the social worker meant that the children didn't have to retell their story each time. In-depth one to one work was carried out with all the children to help them understand their own feelings and experiences and increase their knowledge of their parent's mental health issues. The children really enjoyed having someone to talk to and ask questions about mental health.

Talking to children

Following on from these specific examples of good practice, there were also many other good examples of conversations with children, asking them how they felt including how difficult they may have found the social work contact. There were detailed notes, taking opportunities to praise children and discuss how the parent's condition was affecting their behaviour and their parenting. One social worker explained to the children in one family that,

> *"Mum isn't emotionally well enough to care for the children but that they shouldn't feel guilty"* (Children's Services).

One record of a conversation involved a teenage boy who resented involvement and felt that trust had been broken because they had told school what was going on at home. The social worker arranged for contact to be facilitated in a neutral setting which he felt happier about.

Working with younger children required different approaches, examples of drawing techniques to explore issues with younger children such as drawing a house – 'what makes you happy and sad at home?' were kept on file (Children's Services). When children aren't ready to talk, other methods could be used. A Barnardo's Young Carers worker asked a child to write their concerns on a piece of paper and the worker read it once they'd left the house. After a heated outburst with a parent, one child appeared physically shaken and the social worker arranged to talk to child about the incident and how it made them feel. The file reports that,

> "*Mum is clearly a loving parent who is under a lot of strain and that a strong attachment has been observed between mum and son. Mum has good insight into her own emotions and the impact this may have on her son."*
>
> (CMHT)

This case was referred on to the Family Support team with a reminder that the mother had sought help from CMHT and hopefully the referral will try and prevent the "situation deteriorating further". Mother's illness was explained in an age appropriate as "mum worries and isn't well". The file also stresses the importance of positive contact with the child and to make sure the circumstances are right for the mother to enable this to happen.

Practitioners recognised the importance of talking to children, and needing,

> *"a better understanding of their story"* (Children's Services)

Where conversations were closed, narrative story work was used to help start conversations such as the three houses model in a Together or Apart assessment. Very detailed conversations were recorded with children about how the parent's mental health made them feel. Opportunities to link in early with CAMHS was available. Other age-appropriate examples included the 3 bears story – told as "*daddy bear had moved out of the house because mammy bear was hyper and jumping about all night and baby bear couldn't sleep and this had made them very tired and angry*", giving the child an opportunity to illustrate their feelings. One file expressly noted a request that the new social worker reads the full notes on file in case they upset the children. One file had a joint plan that was illustrated and written out by the children

and jointly signed by all the family members. This included a five-step plan, individualised for each child that detailed the safety measures that had been agreed. These included phoning the children's mother before they were due to visit to check she had not been drinking, an agreement that mother would not drink when they were there and also identified a couple of key people that each child could talk do if they were feeling sad.

Tension between services

There were also some signs of tension between Children's Services and Mental Health – one mental health worker described some families past experiences of Child and Family services as very negative and could impact on future work. One particular file expressed concern that Children's Services had de-registered a child on file without consulting the Mental Health Social Worker, when the MHSW had advised that there should be no unsupervised contact with the children (CMHT). Another case was closed contrary to the Addictions social worker's advice as the parent was still using drugs (Children's Services). Interactions with Children's Services could upset service users. One interaction with a fostering team upset one mother, and her MH SW and Support Worker contacted the fostering team to discuss how best to support her. Children in Addictions files are regularly described as a protective factor or as a coping mechanism, helping to promote routines associated with parenting. However, this is often contrary to child and family social work models that stress that the child should not feel responsible for their parent's wellbeing.

Pressure to perform as a 'model parent' was also mentioned in the files, with play and interactions being observed, becoming sources of stress and anxiety. Parents were described under intense scrutiny at visitation sessions and vulnerable to criticism. One mental health social worker wrote,

> *"From a mental health perspective I had no concerns except the pressure that was being put on [parent] because of the need to be supervised."* (CMHT)

The childcare plan required constant supervision, but the key worker reiterated that there were no mental health concerns,

> *"She has appropriate misgivings about the need for her to be supervised with her child and I encouraged her to be patient."* (CMHT)

Another parent was criticised for only bringing sweets to contact visits but once the child was removed from home, the parent was no longer entitled to benefits and couldn't afford to

prepare a packed lunch. The mental health social worker quietly intervened and asked the carer to pack a lunch for the child. Other file correspondence included a solicitor's letter detailing the stress that child protection was placing on the family.

Work pressures that redirected resources and staff at short notice could also strain working relationships. Meetings to arrange a kinship care assessment were cancelled twice upsetting the parent. Another parent missed a contact session that had been changed at the last minute, a travel warrant was required under bail conditions to attend the alternative venue and the parent had not been advised of this change. This led to an overdose. The service user's mental health social worker wrote to the child protection social worker to ask that they were included in all future correspondence. Other staff had difficulties making contact with the relevant contact,

> *"Tried to get in touch with her child care social worker but have got no response to date"* (CMHT)

Another case file had identified the "*Importance of working with FIS [Family Intervention Service] to safeguard child*" but the family had not been visited by FIS since the pre-discharge meeting six weeks earlier.

Routine administration also led to some strains, there were a number of cases where mental health key workers were missing from circulation lists for child protection case conferences or LAC reviews even though relationships between services were good.

Evidence of interagency collaboration, recognising professional expertise

Although there have been a number of cases identifying some of the strain and professional hierarchy that can play out between Adult Mental Health and Children's Services, there were also many examples of interagency collaboration and recognition and respect of professional expertise. There were examples where Children's Services social workers made direct contact with mental health key workers to use their relationship with their client to engage in services. This was particularly important where service users were discharged from services because of non-engagement. An Addictions key worker contacted Children's Services to highlight the potential risks to the children of the parent's illness and how to respond when these risks were heightened.

Telephone or email exchanges could quickly resolve potentially problematic issues such as helping to arrange contact over Christmas, encouraging parents to engage with services to

facilitate this. One mental health worker phoned her colleague in Children's Services following an overdose and the crisis response team were able to quickly respond and adapt the future care plan. One Children's Services support worker updated the CMHT weekly and in turn, CMHT updated Children's Services on any changes to the a mother's medication and discussed the implications of any changes. There were also records of both services attending meetings together and co-working family meetings including references to joint Think Family assessments. Some families' circumstances were extremely harrowing and traumatic and there was a very clear and strong commitment to joint working of these cases.

Practical issues

There were some practical issues that created additional difficulties for staff and could hamper their work. One clear example is the convention of maternity patients carrying their own notes which meant that their CMHT had no access to them unless the patient wished to share them. Similarly, service users moving between different Trusts could mean that limited information was available on service users. How information is shared between Trusts was not clear in the case files. Some files were very slim in detail, with a number not recording information about other family members or children and containing no paperwork relating to the family on file. There is also some variation in discharge from services across Trust areas. One Trust discharges service users following three 'did not attend' appointments, but in another Trust, patients are discharged after five missed appointments. How 'did not attends' are followed up is also unclear from some of the files. It is difficult to know how best to support families that won't engage but important to try and understand what the barriers to engagement may be. One mother did not engage because she was frightened to lose her children as a result of her codeine dependency. She was ashamed and this is why she wouldn't engage,

> *"I'm not the Mum I used to be…no money, can't give them what they need."* (Addictions)

> "*There are no child protection concerns in this case but she refused to give the social worker permission to talk to other family members, won't speak to the social worker when the children are at home and has been discharged because she won't engage. Mum still needs help.*" (Addictions)

Understanding of the social determinants of health and poverty aware practice

There were also examples of sensitive poverty-aware social work. One Children's Services social worker describe a family's support needs as 'practical, financial and emotional'. There was understanding and observations of the financial problems that were impacting on family

lives – children embarrassed to bring friends home when the house was untidy, rubbish sitting around etc. Reports of financial problems, rent arrears, eviction notices, loan sharks, pawn shops and food bank reliance also featured in a number of accounts and the vicious circle these pressures had on mental wellbeing. Financial help was offered regularly including food hampers, vouchers, and applications for small grants. Signposting to the CAB [Citizens Advice] and St Vincent de Paul was also common. Help for budgeting and financial management was also identified as a financial stressor and some support was offered for families in this area. Christmas could also compound these pressures and organisations such as Barnardo's helped with sourcing presents, food parcels and meat vouchers helping to take some pressure off.

References to resources within files

These included resources developed by voluntary organisations such as VOYPIC's Talking Tool, Barnardo's PHAROS programme and Women's Aid Helping Hands programme. Use of life story materials and children's tools were also used such as ''My Story Book, 'My Voice', 'Words and Pictures' and the Polar Bear booklet. Circles of Safety and Signs of Safety models were also mentioned. The workbooks developed by Jane Hindes on alcohol use were used. Parent resources such as 'Alcohol and me' and 'Cannabis and me' were also observed in case files.

Section 5: Discussion

Complexity of the issues

The complexity of mental illness and substance use

It is clear that professionals are dealing with complex cases and difficult issues that may have lasted for many years, and across generations. 75% of service users had more than one mental health-related diagnosis requiring individualised treatment and support plan and of course every family has their own needs. While there does seem to be available support services, the sheer number of referrals could feel overwhelming for many families particularly during periods where a parent may be unwell.

Social determinants and poverty-aware practice

Poverty and deprivation featured in many of the files and professionals were trying to support families where this was contributing to stress and the management of symptoms. Service users involved with Community Addiction Teams seemed particularly vulnerable to experiencing poverty which is not surprising given the impact that addiction can have on sustaining regular employment, income and managing expenditure. Understanding the additional stress that poverty can place on a family is a key skill and there was good evidence that this was something professionals recognised and responded to (e.g. signpost to relief support, emergency payments, budgeting advice). Poverty-aware practice must underpin working with families and continue to promote social work's role to fight for social justice.

Difficulties with the co-ordination and effectiveness of services

Tension between services

The tacit hierarchy referred to in the literature and acknowledged in practice (placing Children's Services at the top) may create an underlying tension that can limit the control of information exchanged in an attempt to manage judgements and decisions that could undermine service users' recovery. The importance of building a therapeutic, trusting relationship is key to recovery and this could be undermined particularly when there weren't child protection concerns. Prioritising 'the family' as the unit to be offered support and treatment, rather than individual parents or children deemed at risk, may be a less adversarial approach and help promote a collaborative interagency response to co-work cases rather from an individualised harm reduction/recovery vs. the child protection model.

Workload and communication

Workloads were busy, requirements of record keeping could be intensive (particularly in Children's Services involving a handwritten record of every text message, phone call, visit,

meeting attempted or made) and evidence of staff turnover, managing absenteeism and delays to social workers being assigned to cases could add difficulties in the day-to-day management of cases. Routine administration could also be problematic with key individuals missing from circulation lists and missing important appointments including child protection case conferences. How information is exchanged between services and at Trust level needs careful consideration about how this can be improved without adding to workloads, or indeed look at reducing administration to capture important and useful data that could contribute to workforce planning and development, staff training but also contribute to theory development and evidence-based practice. Community mental health and addictions appointments were routinely held within healthcare settings removing the possibility to observe family and home life and the opportunity to build a relationship and understanding of the needs of other family members. The practice of home visits is costly and may carry additional risks for some staff but incorporating some level of contact within a family setting may promote more comprehensive assessment and greater family-focused practice.

Measuring outcomes

Measuring how effective treatment and support is complex. Many families were receiving a large number of interventions but it was difficult to assess how useful or helpful these were from the case file evidence. Many external agencies were involved who were likely to be gathering their own metrics but how this data is shared either between agencies or an individual basis with the service user is difficult to tell from the files. A family may be receiving 12 interventions but few or none may be effective. Similarly, for those parents who find it difficult to engage with services, more needs to be understood why they chose not to engage and explore the potential for family-focused approaches to adapt to promote and facilitate engagement. If a parent does not chose to engage, it is possible to offer support to other family members including identifying and responding to the children's needs.

Examples of good practice

At least 50% of cases were routinely asking about parenting issues and talking to children and this is an encouraging baseline to build from. Dedicated Hidden Harm social workers, who have a specific focus on working with the whole family, and some of the Think Family Champions were able to clearly demonstrate family focused practice in case files and these records had copies of handwritten/drawn resources completed alongside children. Talking to children in an age-appropriate and engaging way is a key skill that should not be the responsibility of Children's Services alone. It is interesting that in the cases selected, Addictions and Community Mental Health workers were more likely to be working with parents with very young children (aged 1-4 years). We don't know how representative these files are,

however, talking to very young children may not be something that the adult mental health workforce undertake routinely or indeed feel equipped or confident to do.

Some files had clear safety plans that could be swiftly put into place if a parent was unwell/using substances and this could help give (older) children a sense of control and understanding of what to do if this happened. This approach acknowledges that mental health problems can be episodic and making sure a child understands that they can be safe and protected if necessary is a powerful resource. This potentially could avoid a child protection crisis which could be damaging for all members of the family.

Having an adult to ask open and honest questions about their parent's mental health was valued by a number of children. Understanding why a parent is behaving in a particular way, knowing what to expect, and what kind of treatment they are being offered can help allay fears and misinformation. When a child was not ready to have contact with a parent, being able to articulate this with a professional was important. The child had the added reassurance that their absent parent was also receiving support. Children reluctant at the outset to talk about their experiences began to appreciate and value the contact with someone trusted outside the family. When a child did not want to talk to the social worker, alternative means of communication were used to try and help build a relationship. Knowing when to step back from a case and let another support service take the lead was also important in some cases. Child protection and family support can create anxiety and stress for families and knowing how to defuse potentially volatile situations required a good understanding of the mental health issues and trust between professionals to respond in an appropriate way.

Examples of missed opportunities

There were also signs where opportunities to de-escalate situations or prevent child protection measures were missed. One particular case led to a prosecution for school non-attendance. Understanding how to support an acutely depressed parent to get their child ready for school would have perhaps avoided legal action and the subsequent stress-induced psychotic episode. A range of factors, including poor lines of communication between Education Welfare and the CMHT, may have contributed to this situation escalating. There were also examples of conflicting decision making and children/contact removed or reinstated based on Children's Services assessment that had either not consulted with the mental health key worker or was contrary to their advice. There was one case where the children were returned to the parent's care where the mental health worker judged to be unsafe for the children, similarly there were a number of examples where children were removed because of safety concerns where the mental health worker had none. Improved communication, mutual understanding and joint

decision-making would help to avoid these kinds of disagreements and would ensure all partners are fully informed about the complex risks that can be associated with mental health problems.

Section 6: Implications for policy and practice

The findings of this case file audit have reinforced how complex effectively supporting families can be, that there are many examples of good practice but there is an ongoing need to further promote family focused practice. The implications of the audit for policy and practice can be considered in five main overlapping themes: policy and service development; promoting joint working; training; information; and involvement.

Policy and service development

Think Family NI, led by the Health and Social Care Board, has promoted family focused practice through a range of policy and practice initiatives. The audit provides evidence of the positive impact this has had and of the ongoing need for this coordination and leadership to continue. There are examples of excellent practice, notably by the Think Family Champions and Hidden Harm social worker, which demonstrate what can be achieved when workers are supported and resourced to work in more systemic, family focused ways. Ensuring this level of support is provided consistently across children's, mental health and addictions services, and across the Trusts, is an ongoing challenge that should remain a priority for policy and service development. The recent Mental Health Action Plan and the planned Mental Health Strategy provide an immediate opportunity to build on this work and that focus also needs to be reflected across policy and service development in Children's and Addictions services. It was also positive to note practice which was identifying and actively addressing the additional stressors of poverty and this also could be further reinforced in policy and service development.

Promoting joint working

The findings of the audit suggest there are a range of practices which do promote more effective joint working. In addition to inclusion of the importance of Think Family across the relevant regional policies, it appears to effectively promote this approach when family focused practice is a specific part of workers' job descriptions and this is a valued aspect of their role. A very practical example enabler of joint working is the physical location of services. When teams were co-located, the proximity appeared to facilitate joint working and greater opportunities for professionals to meet to both share information and agree co-ordinate intervention. Another aspect of practice which appeared to be important for enabling all the relevant issues to be considered was the use of home visits, including joint visits, which seem to have become less common, especially in adult services. The findings of the audit also highlighted the important role of joint-decision making that acknowledges the role and contribution of everyone involved. Positive communication and joint working across services

does take time and the audit did pick up some of the pressures that workers are trying to manage. The audit also identified that, for some families, the number of professionals and services involved may provide additional challenges and there is perhaps an opportunity to further consider how both professionals and families are supported to navigate the complexities of services

Training

Looking at how people are educated into the professions and how ongoing training is delivered also can provide opportunities to integrate systemic and multi-agency collaboration. Inter-professional education has been demonstrated to increase job satisfaction, help healthcare professionals resolve complex issues and tackle professional stereotypes while creating potential to establish effective working relationships across disciplines. Another key mechanism for promoting joint working and family focused practice is in job training. This includes pre and post qualifying professional courses, and, especially for this audit, opportunities to train with other teams and professionals. Joint training and workforce development that builds on and shares the skills and knowledge of child and family social work on how to engage with families and communicate with children, and acknowledges and draws on the professional training and expertise of mental health professionals and their understanding of the complexity of mental health and substance use problems. Joint training is also an opportunity to address any misunderstandings about others' roles and build confidence to address complex issues. There are also existing training resources, such as the e-Learning foundation programme and e-Learning supervision progamme, which can be used to further support all the relevant workers, across disciplines and services.

Information

A central limitation of the case file audit approach is that it mainly relies on what is recorded to provide an accurate account of practice. It may be that there is more use of family focused approaches, and the support tools which support it (such as the Joint Protocol, the Family Model A5 cards and the Children and Young People's leaflets), than is reflected in the case files but there is certainly potential for much more specific recording (and perhaps use) of these approaches. There also appears to be great potential for the use of standardised outcome measures. There was little evidence, across the files, of the use of such measures which would provide more reliable and valid data about needs and change over time. It is hoped that the introduction of integrated electronic records will promote the sharing of the relevant data and prevent some of the current duplication. Given the pressures on individual workers and services, it may be important to further consider how comprehensive data can be collected and recorded as easily and efficiently as possible.

Involvement

The importance of involvement, of working with the whole family, and facilitating everyone to be involved was also highlighted in the audit findings. This also relates to the importance of involving service users, carers and practitioners in all aspects of developing policy, services, training and practice.

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Appendix 1 *Think Family Audit Tool*

Inclusion criteria. Within the last 12 months:

1. Mental health and/or substance misuse problems that have had or are having a significant and enduring impact on social and personal functioning, including parenting; AND

2. Past or present support from Community Mental Health Team and/or Addictions Team; AND

3. Past or present support from Family Intervention Team or LAC Team.

BACKGROUND INFORMATION							
ID Code		**Gender**		**HSC T**		**SOA**	
Age	15-19	20-24	25-29	30-34	35-39	40-44	45-49
	50-54	55-59	60-64	65-69	70-74	75+	
Which service is the case file from?		Children & Family			**Is the social worker a Think Family Champion?**		YES / NO
		Adult Mental Health					
		Addiction					
Category of mental health problems and/or addictions & reason for referral to services							
Date of First Contact				**Date of Last Contact**			
Living Arrangements							
Other Disability		Learning Disability		Physical Disability		Sensory	
		ASD		Mental Health		Chronic Illness	Other
Current Receipt of Services					YES	NO	

ASSESSMENT							
Dependents							
1	**Gender**			**Resident**			
Age	<12 months	1-4 years	5-9 years	10-15 years		16-17 years	18+ years
Disability	LD	PD	SD	ASD	MH	CI	Other
2	**Gender**			**Resident**			
Age	<12 months	1-4 years	5-9 years	10-15 years		16-17 years	18+ years
Disability	LD	PD	SD	ASD	MH	CI	Other
3	**Gender**			**Resident**			
Age	<12 months	1-4 years	5-9 years	10-15 years		16-17 years	18+ years
Disability	LD	PD	SD	ASD	MH	CI	Other
4	**Gender**			**Resident**			
Age	<12 months	1-4 years	5-9 years	10-15 years		16-17 years	18+ years
Disability	LD	PD	SD	ASD	MH	CI	Other
5	**Gender**			**Resident**			
Age	<12 months	1-4 years	5-9 years	10-15 years		16-17 years	18+ years
Disability	LD	PD	SD	ASD	MH	CI	Other
6	**Gender**			**Resident**			
Age	<12 months	1-4 years	5-9 years	10-15 years		16-17 years	18+ years
Disability	LD	PD	SD	ASD	MH	CI	Other
Any other dependents?						NO YES	No:
Is there another significant carer or someone who has regular contact with the children (e.g. ex-partners, grandparents, older siblings)?						NO YES	UNCLEAR

Does the parent express any difficulties with their children?	Physical Health		Social-Emo		Behaviour		Other _____
Has the key worker identified any parenting difficulties?	Physical Health		Social-Emo		Behaviour		Other _____
What action has been taken?							

Contact with other agencies or services	**Current**	**Historical**
Addiction		
CAMHS		
Children & Family Services		
Education Welfare		
Family Support Hub		
Adult MH Wellbeing Hub		
GP		
Health Visitor		
School		
SPOE		
Voluntary Sector		
Adult/child safeguarding issues?		
Other		

THINK FAMILY INFORMATION – Is there evidence of the Think Family Joint Protocol in the case file?			
Has the mental health issue been explained to the parent?	Y	N	U
Has the mental health issue or addiction been explained to the child (age-appropriate way)?	Y	N	U
Has the impact of mental health on parenting capacity been discussed?	Y	N	U
Has the impact of drug/alcohol on parenting capacity been discussed?	Y	N	U
Has the key worker discussed the role of the child as carer with the parents?	Y	N	U
If the parent (or partner) is pregnant have the risks to the unborn child been discussed?	Y	N	U
Has a UNOCINI referral/pathway been completed?	Y	N	U
If yes, is Mental Health & Addiction Appendix A completed?	Y	N	U
Have the parents been involved in the screening/assessment/care planning process?	Y	N	U
Have the children been involved in the screening/assessment/care planning process?	Y	N	U
Has it been explained adequately?	Y	N	U
Is there reference to Think Family in the case file?	Y	N	U

SUPPORT/SIGNPOSTING				
Any record of additional information being provided to the family?	Meetings with the Family	Y	N	U
	Talking about MH	Y	N	U
	Evidence of Psychoeducation	Y	N	U
	Other information provided	Y	N	U
	Please specify:			
Is there evidence of interagency (more than one team or service) co-operation?	Meeting/s	Y	N	U
	Other direct communication (Phone calls, emails, correspondence)	Y	N	U

Any other observations/comments

Appendix 2 *Examples of family focused interventions*

Child-focused interventions

Children in need of support may be ashamed of the stigma associated with attending treatment and how best to help children to access services needs consideration. Cooklin (Cooklin, 2013) reports positive findings on a small-scale study for a weekly support group for children of PMI which was arranged during a lunch hour in secondary school. It was not seen as 'therapy' by the young people involved. Grové (C. Grové, Reupert, & Maybery, 2015) evaluated a peer connections project, '*Kookaburra Kids Camp*' which provides peer support for children and adolescents living with parental mental illness. The 2-day programme provides respite, psychoeducation, promotes help-seeking and facilitates connections to similar young people. Using mixed methods, n=69 8-12 year olds were tested pre- and post-programme and n=18 children were also interviewed by telephone. The programme improved their knowledge of mental health, and participants were more likely to use an anonymous telephone helpline after attending the programme. The camp provided a place of respite from caring for their parent and the opportunity to connect with peers and seeing positive change in their parents' mental illness was also valued.

The Arkansas CARES project supports children of mothers in residential substance use treatment by aiming to build protective factors through parental supervision and monitoring, nurturing parenting, effective personal skills, academic achievement and age-appropriate development. It also tackles risk factors associated with harsh or neglectful parenting, exposure to violence and home life instability. The project offers onsite childcare, early intervention, early childhood education, mental health support and academic support. Data was collected from mothers (n=2,746) and children (n=4,084) enrolled in a cross-site study of demonstration treatment projects (between 1993-2001). Analysis found five key important factors:

1. Children need integrated diagnostic and treatment services
2. Mothers need parenting support
3. Children are viewed as clients too
4. Children need long-term supportive services in a stable setting
5. Children's programming requires non-traditional funding support

The Women, Co-occurring Disorders and Violence (WCDVS) project is a five-year initiative funded by the US Substance Abuse and Mental Health Services Administration (SAMHSA) that includes a children's study exploring the treatment needs of children (Finkelstein et al.,

2005). A common intervention protocol was designed for children aged 5-10 years with mothers with histories of sexual or physical abuse, substance abuse or mental illness. The programme provided age appropriate interventions to decrease risk factors and increase resilience using a strengths-based framework. The initiative used innovative methods to include mothers when their children were attending treatment such as a craft group for mothers run concurrently with the children's group, providing dinner for the families after each group, providing child care and hosting parallel training sessions for the mothers.

Cowling and Garrett (Cowling & Garrett, 2009, 2012) describe a child-focused intervention for parents attending a community adult mental health setting. The programme uses a strengths-based approach with children seen as of equal importance in the recovery model. Service users experience a combination of family and individual sessions. Separate sessions were useful in providing opportunities to engage with children, and which recognised the different ways in which adults and children tell stories of their experiences. Children could communicate their concerns openly and mitigated against 'loyalty binds' that can act as a constraint to inclusive family therapy (Sheinberg & True, 2008). It is also helpful for parents who are sensitive about the impact of their illness and feeling guilt and shame (Diaz-Caneja & Johnson, 2004) and parents may actually want help explaining their illness.

Barnardo's *Action with Young Carers* project, *Keeping the Family in Mind* works to improve and enhance the range of appropriate and accessible, non-stigmatising and timely services to families with children impacted by parental mental illness. Working across children's services and adult mental health services it aims to raise awareness and conduct outreach work. Initial work involves building trust, a six-month assessment based on 'Every Child Matters' outcomes, and sharing accurate information with children about parental mental illness. Project workers can be contacted at almost any time, and creative approaches to engage children are used. Rooms are child-friendly and assessment is "incorporated into activities as a continuous process rather than a one-off event." (G. Grant, Repper, & Nolan, 2008, p. 274). Emphasis is placed on both the parent's and child's perspective and projects are devised to be fun, building on trust.

Family-focused interventions

Many of the family-focused interventions are strengths-based and focus on risk and protective factors. *KTS-WFT* was established in New South Wales, Australia in 2010 "in response to need for collaborative partnerships to stop families with complex and multiple problems falling between the gaps of service delivery" (Coates, 2017, p. 2) with the core concept of making

"families safer places for children" (Coates, 2017, p. 2) and fundamentally change the way children are supported and protected. Four WFT pilots were established and referrals are taken from child protection, and the programme offers interventions to families with parental mental health/drug and alcohol problems where there are child protection concerns. It stemmed from an enquiry into child protection services in New South Wales which found that families coming into contact were characterised by a range of complex and inter-related factors; elimination/reduction of each of these risks could significantly lower the number of children at risk of harm however, "no one agency can address all these factors" (Coates, 2017, p. 2) however collaboration between agencies could help protect vulnerable children. It aims to provide comprehensive assessments and a range of interventions for the whole family for up to 6 months with interventions focused on building resilience in children, increasing parental capacity through parent skills training, mental health and substance misuse interventions. Around n=205 families (n=772 individuals) have been involved in the programme between April 2011 and June 2014 and positive outcomes have been reported for families (Coates & Howe, 2016) including positive changes in family functioning and safety.

The *Family Options* model provides family-centred care management for parents with mental illness and their children. It is delivered within a standalone community mental health agency and is a strengths-based recovery and resilience model providing wraparound support at both community and home-based level. 24-hour, seven-day support is provided through home visits, a telephone helpline and a small pool of discretionary funding. Three full-time Family Coaches work one-to-one with families with the aim of helping parents to: identify and prioritise with parents, the needs and strengths of each family member; and work collaboratively with parents to build trusting relationships related to family strengths, needs and goals. In order to deliver the model, workforce, organisational and community capacity required development. Once the relevant skills were identified, recruiting staff with relevant experience proved difficult. Staff were trained to deliver the model, with regular training targeted to respond to the challenges encountered delivering the model.

Beardslee's Family Intervention is a preventive intervention for children of depressed parents in Sweden. The *Family Intervention* aims to prevent occurrence of mental health problems in children of parental mental illness, promotes mental health and resilience by strengthening parenting and supporting parents to be open about their illness, and enhance well-known protective factors for their children. Important elements of the programme include: reducing guilt and shame to facilitate communication, respecting the parent, providing psychoeducation material linked to family's own experiences. The intervention is manualised and has an eclectic foundation including psychoeducation, cognitive, dialogical and narrative. N=103 families

were recruited who had used the *Family Intervention* in 2007 with children aged 8-18 years. Parents and children were generally satisfied and reported a positive impact (Pihkala, Cederstrom, & Sandlund, 2010).

Huebner (Huebner et al., 2017) considered ten years of implementing and evaluating programmes supported under the Regional Partnership Grant (RPG) in the US, designed to meet the needs of families affected by parental substance use disorders and child maltreatment. Legislation (the Child and Family Services Improvement Act of 2006), awarded competitive RPGs to implement and test integrated family-centred treatment programmes. 53 grants were awarded in 2007, with a further 17 programmes awarded in 2011 under the Child and Family Services Improvement and Innovation Act. The first 53 programmes served n=7,100 families and children involved in these programmes were more likely to: remain at home; be reunified more quickly; had fewer recurrences of child maltreatment, and; spent less time in foster care. Parents involved in the programmes spent more time in substance use disorder treatment, showed greater reduction in substance use, and were more often in employment at case closure. One of the programmes implemented under the RPG was the Sobriety Treatment and Recovery Team (START), a child welfare programme designed for families with children up to five years old with substantiated CAN and parental use. Families had to have an open child welfare case and be referred to START within days of the child protection investigation being initiated. START paired specially training CPS workers with peer recovery supports (family mentors). The teams of two shared a capped caseload of 12-15 families and provided intensive welfare services including frequent home visits and family team meetings. Secondary data analysis of case review results compared START cases to non-START cases within the same county sites. START cases consistently received higher ratings of adherence to best case work practices, better family engagement in decision-making, quality of attachment and contact with fathers than non-START cases. Stakeholder interviews and focus groups were also coded and analysed which described some of the difficulties delivering family focused practice particularly associated with working with substance use disorders and vulnerable children. Staff challenged each other about practices including child placement and removal, drug testing, and expectations of parents in treatment. Service development also included contract agreements and a common data collection system, with administrative data used to monitor and set targets for treatment fidelity. State and local leadership was required, along with multiple cross-training opportunities, state-level workshops, seminars and frequent meetings. Monthly ‘direct line’ meetings with all START staff were held and regional and state meetings were dedicated to resolving issues that could impact on collaboration. Standards of service delivery forced child welfare and substance use disorder treatment providers to jointly develop and implement solutions to problems of parental

access and retention in treatment. The integrated treatment model took at least three years to embed with clear signs that attitudes and values had started to change. Treatment fidelity began to dip again in year 4, so continual monitoring is recommended to maintain treatment standards. Cluster analysis of closed cases found that some families didn't benefit from the intervention and failed to regain custody of their children. These families tended to have younger children (new borns and infants) suggesting that young parents losing custody may benefit from more help to form attachment and parenting skills to build confidence. Fathers were also found to achieve lower rates of sobriety than mothers and gender specific treatment may be more successful.

Further qualitative work was conducted by Reupert, interviewing n=10 practitioners over a 15 month period, every 4 months (A. Reupert & Maybery, 2014) and examined the barriers and difficulties working with families with parental mental illness. *Northern Kids Care – On Track Community Programs (NKC-OTCP)* is a non-governmental organisation which is run in various centres across New South Wales. Families have drug and alcohol abuse problems, mental illness or both and to be eligible to join the programme must be on a mental health plan. A one-year intervention programme delivers family-sensitive practice and strength-based case management with the family as the unit of attention – different family members are acknowledged to have different strengths and needs, at different times. Strategies they found successful include identifying critical periods that can help make positive change in families including intake, initial case conference, periods of crisis periods and planning for discharge. Goals need to be clearly defined and negotiated and practitioners with skills to work with children and adults is required.

Isobel reports on a nurse-led emotional awareness parenting programme for adult clients of mental health services in Australia (Isobel, Meehan, & Pretty, 2016). The six-week 'Tuning In To Kids' recruited a small number of participants from inpatient and community mental health teams and although self-reported benefits were positive, there is no follow-up data.

Gatsou's focus groups with professionals delivering the Family Intervention Programme in the UK involved N=15 professionals (Gatsou, Yates, Goodrich, & Pearson, 2017). The 'Think Family/Whole Family' Programme draws on core elements from the Meriden Family Programme which was developed to support families of young people with psychosis. It provides a practical, skills-based psychoeducational intervention focusing on day-to-day differences. Family members are encouraged to work on recognising early signs of relapse, and to develop plans for staying well and working towards recovery. It promotes positive communication, problem-solving skills and stress management. The concept of 'family' is

understood in broad terms and defined by the service users themselves. A two-day training package was developed to work with families with a wider range of mental illnesses and sources of distress and to focus on parental mental illness over an eight-session intervention protocol. Feedback from training reported increased levels of confidence in the professionals, greater understanding of PMI and its impact on families and the importance of engaging all family members. Professionals also learnt new things about existing clients, and the training helped develop and build trust and rapport with family members helping to facilitate more effective work. The family-led, voluntary nature of work facilitated changes to practice in diverse settings which led to new referral practices, improved information sharing and joint working and adopting tools for use in routine practice. By the end of the intervention, families were more openly discussing impacts of parental mental illness which had previously remained or were unspoken about leading to improved relationships, less conflict and a more supportive environment, increased awareness of the impact of parental mental illness on the family, and increased awareness of other family members of symptoms of illness and the impact on the ill parent.

Partners with families and children is a strengths-based, family centred practice based on wraparound service principles and attachment theory. The Partners model wraps a team of professionals, friends, and extended family members around each family affected by chronic neglect to create an individualised, strengths-based service plan. Treatment includes onsite, gender-specific, integrated substance use and mental health treatment for parents and interventions to strengthen parent-child relationships. Teamwork is considered the central mechanism for therapeutic change, with the parent at the centre. Services provided match each family's needs and address immediate or anticipated problems such as relapse, or loss of housing or employment, which could obstruct overall goals of service plan. This multi-disciplinary approach aims to link parents to needed resources such as housing, employment, and transportation and helps them set and achieve measurable goals. Families are assigned to a family team co-ordinator who completes an initial formal assessment and develops a team of professionals and family members to participate in service plan development and delivery. Programme evaluation found that participants reported significantly better access to and uptake of health services and other supports, decreases in child concerns and lower numbers of serious violence assaults.

Examples of protocols

Clark (Clark & Smith, 2009) reports on a trial implementation of a protocol to enhance interagency collaboration for Children of Parents with Mental Illness (COPMI). Developed by a working group of partner agencies with consultation with consumers, family members and

other stakeholders, it was designed to provide a framework for problem solving and knowledge building and which could be tailored to local contexts. The implementation of the protocol was supported by a number of different strategies including an advisory committee, local interagency committees and cross-agency staff training. Results were positive: collaborative work and communication with COPMI and other agencies had increased. 84% of respondents said that collaboration made their jobs easier by enhancing work with COPMI, time efficiencies and they benefitted from other staff's expertise. The holistic approach allowed for more complete information about the clients and resulted in better outcomes for children and families.

Radcliffe examined a nurse-led service to promote contact between families/carers of inpatients on an acute psychiatric ward and ward staff in the UK (Radcliffe, Adeshokan, Thompson, & Bakowski, 2012). A four-session protocol was established across three acute psychiatric wards aiming to engage reluctant carers. The service aimed to provide family members/carers with emotional support, advice and information, obtain information about the patient, establish a working alliance and refer family members on where appropriate. Three regular ward nurses provided the service and the training was delivered over two afternoon workshops. Fortnightly operational supervision was provided by the lead nurse. N=78 families (54% uptake) were seen in the first year, with most needing between 1-2 sessions. High levels of satisfaction were reported with benefits including having someone to talk to, better communication and information about the illness and specific help e.g. managing medication, treatment, post-discharge and onward referrals. N=8 staff members were also interviewed and they reported better engagement of carers in the treatment pathway, improved understanding of mental illness and greater trust and improved relationships between families and mental health services. There were also fewer formal complaints.

The *Family Options* model developed a 'Family Strengths Assessment Form' and a 'Family Goal Form' (Biebel et al., 2014). Protocols and procedures were operationalised to suit serving whole families. For many tasks, existing agency protocols could be amended. Flexible funding procedures were developed to quickly respond to a family's financial pressures which were in line with the family's goals. Communication pathways were facilitated among all components of the agency and regularly scheduled resource-sharing meetings were held with the larger home agency – shared information and resources and increased marketing of the Family Options model ensured stakeholders were up to date on relevant intervention activities.

The Integrated Assessment model described by Jarpe-Ratner, designed to enhance the quality of clinical family assessments also was found to support frontline child welfare

caseworkers in their implementation of family-centred, strengths-based practice and was found to be particularly useful in complex cases (Jarpe-Ratner & Smithgall, 2017). It was devised following an evaluation of the psychological assessments conducted by Illinois DCFS found that referral questions were not comprehensive, focus excessively on individual pathology, overlooked family dynamics, and was found to compete and not complement caseworker judgement. A clinical screener (with a least a master's degree in social work/related field and three years of mental health or early childhood experience) was paired with a child welfare caseworker to facilitate a joint assessment that allowed the caseworker to spend more time with the child and family. A supervisory structure was in place to provide independent administration and clinical support for each professional. Caseworkers maintains primary responsibility for child welfare case and continually engages family in all aspects of the legal and child welfare processes. The screener provides specialised clinical consultation and takes lead role on integration of information and report-writing – role ends after 45-day initial assessment period. Theory of change behind the model – the information in report and collaborative process between caseworker and IA screener will lead to earlier identification of family needs and strengths and more appropriate interventions for the child and family. Evaluation found that there was a timely completion of assessments and greater inclusion of fathers in the assessment process. This qualitative study was part of a larger 5-year mixed-methods evaluation, n=53 caseworkers and the feedback was largely positive. However, some difficulties included: negotiating schedules with the screener could be difficult; perceived inefficiency of having two people conduct interviews; concern around client engagement and bringing another professional into their practice space – but these were largely unfounded once practice started. The positive experiences included: produced more information sooner; very high risk cases, reassuring to have someone else to clinically consider case; experiencing interaction is more valuable than just reading a report; gave caseworkers time to listen when screener was taking notes; negotiating agreement on the assessment report content IA screeners seen as more optimistic/idealistic; for those cases that weren't randomised – worker would have appreciated screening input for difficult cases including parental mental health concerns particularly dual diagnosis; provided them with additional support in decision-making; gave opportunities to gain an overall strengths-based perspective of the family.

Stanbridge and Burbach (Stanbridge & Burbach, 2007) describe the use of Somerset County Council's 'Strategy to enhance working partnerships with carers and families' (2002) as a useful exercise in bringing together families/carers focused services. This led to service development which routinely offered: family friendly units with appropriate facilities; interventions that considered the client in the context of their relationships; involvement of families and carers in assessments/admissions; close collaboration with other agencies;

formal carers assessments and care plans where appropriate, along with carer support initiatives; early referral including for family members; and greater consideration of children in families including child protection issues, impact of PMI and children's roles as carers. A Carers and Families Steering Group was established comprised of carers, service users, managers, clinicians and service providers which met bimonthly. As a result, information and support for carers has improved, involvement of families/carers in the assessment and treatment process has increased and staff have developed new skills working with families. Trust policies and guidelines have also been reviewed in light of these changes. A range of awareness/basic skills training packages have been developed and systematically implemented throughout the Trust.

Dunst's (Dunst & Trivette, 2009) *Enabling and Empowering Families* intervention has eight conceptual principles which has led to the development of a set of assessment and intervention practices, easily used by professionals from various disciplines and backgrounds. It involves the adoption of both a social-systems perspective of families and a family-systems definition of intervention where the family is the unit of intervention (not just the child). The primary emphasis is on family empowerment, using a strengths-based approach and seeks to use a family's informal social support network as a primary source of support and resources. These principles have developed an operational framework to guide assessments and intervention practice.