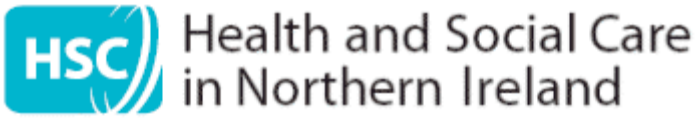

THINK FAMILY

NORTHERN IRELAND

Introduction

Mental health and wellbeing of children and adults in a family where a parent has a mental health issue are closely linked. Not all families need health and social care services, but those that do often struggle to get accessible and effective support that addresses children's needs and recognises the parental responsibilities of many adults with mental health issues.[1]

In Northern Ireland there have been a number of cases where children have been seriously injured or have died and enquires into the circumstances surrounding these cases identified parental mental health and deficits in communication and joint working between professionals and agencies as contributing factors suggesting that the way in which these services work together needed to be improved.

The Department of Health Social Services and Public Safety (DHSSPS) funded two project managers for three years to lead the implementation of a plan to address these issues. Between April 2009 and March 2012 the Mental Health Children's Services (Think Child, Think Parent, Think Family) Project worked with adult, mental health and children's services in the statutory and voluntary sectors across Northern Ireland. The project vision was to improve outcomes for parents with mental issues and their children by establishing a 'Think Child, Think Parent, Think Family' approach to the planning and delivery of services.

Focus

The project focused on improving collaborative working and enhancing understanding of multi-disciplinary roles and responsibilities of all stakeholders working across the Mental Health and Children's services interface. Introducing the Family Model[2] as a beneficial conceptual tool has assisted staff in thinking about different family members, their relationships with each other and the impact of external environmental factors. A key concept of the project was to harness and strengthen what is already happening with a Think Family approach.

In July 2009 the Northern Ireland project joined, as a regional pilot site, a national initiative led by the Social Care Institute for Excellence (SCIE)

[1] Social Care Institute for Excellence (SCIE) Evaluation report February 2012
[2] Falkov et al

aimed at making improvements in the provision of services, when working with parents with mental illness and their children. SCIE published guidance[3] to assist staff working with parents with mental health problems and their children. The guidance was revised and updated in 2011,[4] and identified what needed to change, making recommendations to improve service planning and delivery and ultimately to improve outcomes for families. The guidance provided a framework for implementation of this important initiative within Northern Ireland.

There are nine priority recommendations Identified within *Think child, think parent, think family: a guide to parental mental health and child welfare'* (Social Care Institute for Excellence 2009, revised in 2011). Nine recommendations draw together the best of current practice alongside a renewed emphasis on thinking about families and cover:

1. Signposting and improving access to services
2. Screening
3. Assessment
4. Planning care
5. Providing care
6. Reviewing care plans
7. Strategic approach
8. Workforce development
9. Gathering more evidence about what works

The implementation of the project has to an extent followed a linear process using the nine recommendations as its framework. Plans were agreed with specific outcomes which were then implemented and progress reviewed. The process has also been organic in nature responding to opportunities and changes in the practice and policy environment. Changing attitudes and ways of working takes time and future progress will require continued commitment from organisations, managers and practitioners/clinicians

[3] (Social Care Institute of Excellence 2009) *Think child, think parent, think family: a guide to parental mental health and child welfare.'*
[4] (Social Care Institute of Excellence *Think child, think parent, think family: a guide to parental mental health and child welfare.'* (revised 2011)

Throughout the Think Family Project substantial progress was made in seizing every opportunity to embed a 'Think Family' approach into new and existing regional and local initiatives, policies, guidance, training and structures. However, there is still a need to further change organisational culture and understanding of what falls within individual's remits, supported by senior management to ensure the necessary changes continue.

Structure (2009-2012)

The project structure consisted of a Project Board with membership comprised of senior management from relevant adult and children's statutory and voluntary organisations and service users and carers. Project Board members provided overall direction and guidance and were responsible for developing and embedding the Think Family approach in their own organisations. They also attended a workshop to prepare them for their role. The workshop focused on testing their values and ensuring commitment to the task at hand.

Project Locality Teams (PLTs) were established across the five Health and Social Care Trusts areas which were representative of statutory and voluntary organisations and service users and carers. To do this, two regional workshops were delivered to create initial awareness and discussion on how to move forward. Regular meetings were also held with the five chairs of the PLTs to maintain motivation, focus progress action plans and address challenges along the way.

Each PLT developed an action plan for their locality based on the first six SCIE recommendations, whilst the two project managers specifically focused upon recommendations 7,8,9.

PLT chairs were ultimately responsible for driving forward planning and delivery of the changes required to implement the SCIE recommendations. This structure facilitated a consistent approach to change and promoted learning across the project locality team.

Activities to implement SCIE good practice recommendations

A range of activities were undertaken at regional and local level to implement the SCIE recommendations. These activities are summarised under each priority recommendation.

Signposting and access to services

In implementing the first recommendation the Project Locality Teams considered how best to provide information for service users, their children and family members, and the general public in a positive way without further stigmatization of this client group. The focus was on promoting a positive message about accessing support, reviewing staff perceptions as a mechanism to change attitudes, and developing staff awareness of the full spectrum of services available relating to mental health, parental support and support for children.

Outcome

- Development of a communication strategy, clearly setting out the aims and objectives of the project.
- Organisation of a publicity campaign, linked with other information activities across the region, to promote a positive message about accessing support as a means of addressing the stereotypes, stigma and fears that the public may have about accessing mental health and children's services.
- Publication of Think Family project newsletters to raise awareness of the project among staff and improve their knowledge of the full spectrum of services available relating to mental health, parental support and support for children.
- Development of Health and Social Care Board's (HSCB) 'Think Family Project' web page which provided information relating to the project; local contacts, local events and changes to service delivery, newsletters and support information for service users and staff - http://www.hscboard.hscni.net/Thinkfamily/.

Involving service users

Meaningful engagement with service users and staff who provided the services was essential to the success of the project. This was achieved by developing a regional voluntary organisation sub group that supported and provided services to service users and carers.

A specific piece of work completed with this group was the Family and Staff Experience SenseMaker surveys. Parents with mental health issues, their children, carers and staff were asked to complete a survey, either online or on paper. They detailed their experiences of services and measured their experience against predefined signifiers using a question framework.

The methodology used a qualitative approach which presented the qualitative data for analysis in quantitative format, identifying patterns and trends for analysis, interpretation and use for action. Results of the surveys have influenced and directed on-going developments within Phase 2 of the Think Family work in Northern Ireland.

98 family experiences and 280 staff surveys were completed. Communication and information sharing between families and professionals, although improved, still remained a concern for many respondents.

Professional commitment to patient confidentiality over-riding the information needs of the family was cited as a reason for poor communication, leading to little or no consultation with family members and questions being left unanswered.

Children indicated that not being informed or included in the planning process caused anxiety, fear and feelings of isolation. Service users, their children and carers clearly indicated that not understanding the parent's condition negatively impacted on families, especially children.

Results from the survey indicated that where the needs of the ill parent and children/family members were considered jointly by staff involved it led to better recovery for the parent, positive outcomes for both parent and children, and greater levels of service satisfaction.

Screening

A major aim of the project was to ensure that the Think Family model was embedded into practice through systems which routinely and reliably identified and recorded information about adults with mental health issues who are parents, and their children and family members. This ensured that from the outset of engagement with the family screening processes elicited the right information for appropriate assessments and referrals or supports to be offered to meet the families' needs.

Outcomes

1. Revision of existing screening/assessment tools across maternity, mental health and children's services to promote a family model approach to the assessment and treatment process at a local and regional level.

Development and circulation of a list of age appropriate resources to assist staff and parents in talking to children about mental illness.

<u>Assessment/ planning care/providing pare/reviewing care</u>

Through a series of workshops, using the SCIE priority recommendations relating to assessment/ planning care/providing care/reviewing care, staff identified the changes required to improve service provision, with each PLT area developing an action plan to address the identified changes.

To guide and support staff to more effective partnership working, a regional Adult and Children's Joint protocol was developed.[5] The protocol set out the principles and best practice guidelines that staff must consider when responding to the needs of parents with mental health issues, including substance misuse, their children and families.

This is set in the context of promoting a Family Model through a collaborative approach to service delivery and effective communication between all stakeholders. The protocol promotes that families affected by mental health issues may benefit from the provision of support and intervention at an earlier stage thus preventing children becoming 'at risk' and enhancing recovery.

[5] Adult and Children's Services Joint Protocol: *Responding to the needs of children whose parents have mental health and/or substance misuse issues.* (HSCB 2011)

UNOCINI (understanding the needs of children in Northern Ireland)

The UNOCINI (Understanding the Needs of Children in Northern Ireland) is a regional comprehensive assessment process and is also used as the basis for referrals to statutory children's services to identify the needs of children. A review of the UNOCINI guidance for staff highlighted that parental mental health was not explicitly covered. It did not provide for the detailed elements of parental mental health that staff needed to consider when completing an assessment of a parent who has mental health issues.

UNOCINI was revised and an appendix developed to better reflect what practitioners should know and take recognition of when completing UNOCINI assessment when a parent has mental ill health issues.

Outcomes

1. Development of Regional Joint Protocol to facilitate joint working between adult' mental health and children's services.

2. Development of UNOCINI appendix 1 , *A Guide to understanding the effect of parental mental health on children and the family* (2011).

http://www.dhsspsni.gov.uk/microsoft_word_-_a_guide_to_understanding_the_effect_of_parental_mh_on_children_and_their_family_june_2011-2.pdf

Workforce development

As health and social care services, systems and practices develop it is important that training and workforce development are in place to provide staff with the necessary knowledge and skills to embed a 'Think Family' approach into practice.

Outcomes

A range of workforce development activities ran during the project. These included:

1. Awareness raising.
2. Inclusion of 'Think Family' approach into existing training.
3. Practitioner champions groups were established across 3 of the Health and Social Care Trusts.
4. Development SCIE e-learning materials.
5. A customised multi-disciplinary training course for managers focusing on the skills needed to implement a Think Family approach and risk management processes has be developed to be provided regionally.
6. Development of a Knowledge and Skills Framework.
7. Liaison with Higher Education Institutions to incorporate the 'Think Family' principles into existing professional training programmes.

Strategic approach

At a strategic level there was contribution to a number of on-going initiatives aimed at ensuring the Think Family approach principles were consistently incorporated into the development and planning of services. Key regional initiatives are listed below:

- Bamford Task Group
- Hidden Harm Quality Assurance Group
- Children and Young Peoples Strategic partnership.
- Promoting Quality Care Implementation Groups
- Card Before You Leave
- Mental Health Service Framework
- Children's Services Framework
- Perinatal Mental Health Implementation Strategy
- Area Child Protection Committee training sub group

Outcome/Performance Measures

Initial scoping work showed that few suitable indicators existed. With support from the Health and Social Care Board indicators were developed. These were based on primary data collected from service user and staff family experience surveys and case file audits.

Ten services from each of the five Trusts were asked to complete a self-audit of case notes set against SCIE good practice standards:

1. Gateway services
2. Family intervention service
3. Public health nursing (health visiting)
4. School nursing
5. Child and adolescent mental health service maternity services
6. Community mental health services
7. Acute inpatient mental health services
8. Addictions services
9. Forensic services

215 returns were received with approximately 25 returns per service regionally. Although this was a relatively small audit results were consistent across services and Trusts. From the audit evidence clearly showed that services were beginning to assess the impact of mental illness on the wider family.

Results also indicated that staff were beginning to consider how mental illness can impact upon family life. However the typical case work model of engagement was between the individual and professionals, with little or no engagement with the wider family system. Within case files/records there was limited evidence to suggest that carers were consistently being communicated with or involved in the planning and delivery of care.

Relating to children in general, case files/records showed that children were talked about but not talked to or included in the care of their parent. Where cases were set within formal child protection procedures the needs of children were considered within the case conference plan. But again there was limited evidence to suggest that children had been given information relating to their parent's mental illness or that the children had been included in the planning and delivery of care for their parent.

Recommendations for future work

Further change to organisational culture and peoples understanding of what falls within their remit is required.

There were some key barriers that were encountered which would benefit from further investigation:

1. Further exploration to ensure a clear care pathway exists for families where a parent experiences mental ill health. This should include identification and needs of families who fall into the 'lower level' support.

2. Technical solutions to link up children's services databases with mental health databases to assist in the identification and assessment of need for families and children.

3. Although outcome / performance measures were developed on a smaller scale, more robust measurement of indicators and evaluation is essential.

4. Information sharing is critical at all stages of the care pathway.Trusts/organisations need to consider how staff communicate relevant information/explanations about mental illness and the impact on family life to;
    a. Carers
    b. Children, either directly or through their parents/carers in an age appropriate manner.

5. Future work to ensure Think Family principles are embedded in professional education at all levels.

Think family NI (2014)

Where we are now - Phase 2

When the Think Child Think Parent Think Family Project ended in October 2012 it became core business for the HSCB. Phase 2 of the Think Family work is now under the structure of Children & Young Peoples Strategic Partnership (CYPSP) which is led by the HSCB http://cypsp.org/

A new dimension brought to the work is the development of Thinking Family in its widest context that includes not only the impact of dependent children and young people but also those adult carers who continue to care for their adult children who have mental health issues.

A regional workshop was held to develop our thinking of how Phase 2 of Think Family should commence. A regional Think Family sub group was developed consisting of adult mental health, children's and voluntary organisations from existing and new membership.

Terms of reference were developed, which clearly focused on learning from the project. The focus of the work has been based on realistic achievements to ensure that the benefits are meaningful for families and that it clearly makes a difference for them.

An exciting development for Phase 2 of Think Family is the achievement of commissioned support from Dr Adrian Falkov, author of The Family Model Handbook. The Family Model will be used in Northern Ireland as the framework in a pilot project taking place in the South Eastern Health and Social Care Trust. The pilot project will make the necessary changes using the family model to build upon and strengthen a family focus.

Dr Falkov has delivered two regional conferences in Northern Ireland and is currently providing support to the Pilot Project which is a specific area of work stemming from the Regional Think Family Action Plan.

Regional Think Family Action Plan

The Regional Action Plan is based on the themes for learning from the family and staff experience surveys undertaken within the Think Child Think Parent Think Family Project. The themes from the surveys relate to:

- Improved communication between professionals and families
- Improved access to early intervention family support for children, young people and their families
- Improving the extent to which assessment, planning and treatment is inclusive of a 'whole family' approach.

All of the following will form the basis of our work for the future combined with robust evaluation that will be taken forward in partnership with academics and practitioners.

What have we done to date?

- Developed leaflets for children and young people giving them information about mental health issues relating to their parents and carers.
- Launched the children's and young people's leaflets in each Health and Social Care Trust area and provided awareness sessions relating to the Phase 2 of the Think Family work.
- Continued to ensure that Think Family shapes and influences strategic direction. This allows a strengthening of collaboration at this level so that partnership approaches to regional changes reflect a Think Family approach.
- Developed performance indicators using a recognised methodology to measure areas within the regional action plan. This work is being taken forward in partnership with Dr Adrian Falkov, the Safeguarding Board Northern Ireland, academic institutions and practitioners, and will form an important and integral part of Phase 2 Think Family work.
- The pilot project in the South Eastern Health & Social Care Trust is made up of adult mental health, addictions, acute inpatient, children's and three voluntary organisations and will start in September 2014, covering a period of two years and will occur in three phases.

The pilot project - Phase 1

Phase 1 will strengthen documentation in the above service areas with information from COPMI (children of Parents with Mental illness) www.copmi.net.au . During the Think Child Think Parent Think Family project information from COPMI was used to strengthen documentation within various service areas.

During Phase 2 of Think Family it is important that COPMI information is reviewed to strengthen further and based on the revised and updated Family Model.

How will this work?

- Staff will begin to use the strengthened documentation upon initial referral for all families presenting.
- Those that need lower level family support will be referred to the Family Support Hubs that have been developed under CYPSP. This starts the process of changing the culture of how you think and practice.
- Those families who are assessed as needing further involvement into the Community Mental health team will continue to get a family focused approach.
- If the person's mental health deteriorates the family focus will continue during their admission into the acute inpatient ward in the Downe sector of South Eastern HSC Trust.
- On discharge from the inpatient ward, the Community Mental Health Team will continue their involvement and provide a family focused approach using the Family Model concept.

Phase 2

Phase 2 will focus primarily on adult mental health (AMH) staff having the family conversation. This includes increasing the knowledge and skills of AMH to make the family focus their core business.

How will this work?

- AMH will have specific training to build their knowledge and skills in talking to children and young people.

- Upon referral to AMH staff will engage the person in conversation reflecting on questions in the strengthened assessment and review documentation.

- Voluntary partners in the pilot will assist AMH to have conversations with children and young people and with adult carers to begin the process of the family conversation.

- This process will allow families to become involved from the outset in assessment, planning and review of their care, building upon the importance of the strengths and support within the family as appropriate.

Phase 3

Phase 3 will focus on the environment of the facilities, including upgrading family rooms in the addiction and acute inpatient ward to allow family visits to occur in a more stimulating environment that enhances engagement for the parent and their dependants.

How will this work?

- Voluntary organisations will use their existing young carers group to agree how and what should be provided in the family rooms in addictions and inpatient wards.

- Use of local facilities for family conversations to reduce stigma and enhance motivation.

- Develop a Think Family social assessment for use by social work staff using the Family Model domains.

In conclusion

Phase 2 of Think Family is an exciting and challenging development for Northern Ireland. We may not achieve all that we hope for, but in doing all of this work the emphasis has to be upon ‘including the family in conversation’. If the focus on the family continues as a priority, by listening to what families want, need and how they can help in the recovery of their parent or carer, it will make a difference.

Using the Family Model as a framework will give focus and purpose to the development of this work. The commitment and willingness of organisations, management, and staff in Northern Ireland to change their thinking and practice to become family focused at every level has already begun. There is more to do and it will be a journey that will see success and challenges, however, if we accomplish what we set out to do we will have achieved and delivered a more meaningful service to families.

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