Are we starting to 'think family'? evidence from a case file audit of parents and children supported by mental health, addictions and children's services

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SHORT REPORT

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Are we starting to 'think family'? evidence from a case file audit of parents and children supported by mental health, addictions and children's services

Claire McCartan[1] | **Gavin Davidson**[1] | **Mary Donaghy**[2] | **Anne Grant**[3] | **Lisa Bunting**[1] | **John Devaney**[4] | **Joe Duffy**[1]

[1]School of Social Sciences, Education and Social Work, Queen's University Belfast, Belfast, UK

[2]Health and Social Care Board, Belfast, UK

[3]School of Nursing and Midwifery, Queen's University Belfast, Belfast, UK

[4]School of Social and Political Science, University of Edinburgh, UK

Correspondence
Claire McCartan, Queen's University Belfast, 2-8 Fitzwilliam Street, Belfast BT9 6AX, UK.
Email: c.j.mccartan@qub.ac.uk

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Key Practitioner Messages

- Cases are complex and families can feel overwhelmed by the number of agencies and referrals involved.
- Systemic, family-focused practice can lead to improved outcomes; this should be consistent across mental health, addictions and children's services.
- Efforts to promote interagency collaboration include: clear job descriptions; co-locating services; home visits; inter-professional education; and joint training. Joint decision-making can help acknowledge and value everyone's role and contribution.
- Better recording and sharing of data can support informed, complex decision-making and optimise support services.

BACKGROUND

Globally, it is estimated that anywhere between 12 and 45 per cent of adults receiving mental health treatment are parents and up to one quarter of the child population lives with at least one parent with a mental health problem (Reupert & Maybery, 16). While the impact on parenting varies across the wide spectrum of mental health and substance use problems, many children will experience cognitive, emotional, social, physical and behavioural issues, and they will be exposed to other commonly associated stressors such as poverty, isolation, instability and stigma that can negatively affect family life (Royal College of Psychiatrists, 17).

Northern Ireland has the highest prevalence of parent mental health problems in the UK, with similarly elevated rates in the child and adolescent populations (Abel et al., 1; Bunting et al., 4). Recent research found that children in Northern Ireland were twice as likely to have an anxiety or depressive disorder if their parent reported mental health problems themselves (Bunting et al., 4).

Family-focused practice (FFP) provides support to a service user by acknowledging the context of their family relationships and endeavours to meet the needs of the whole family (Lagdon et al., 13). FFP can be beneficial for the whole

family when parents have mental health and substance use problems (Cooper & Reupert, 6). The type and intensity of activities/processes may be influenced by the professional discipline, service type and beliefs about FFP (Maybery et al., 14). However, staff may work in isolation from other disciplines, guarding their professional territory amid fear of trespass, particularly if another service is seen as 'responsible' (Baistow & Hetherington, 3; Cowling & Garrett, 7). Uncertainty over professional responsibility for children where parental mental health problems are a concern has created tension within the social work profession, where perceptions of hierarchy can prioritise one service (child protection) above another (mental health/addictions) (Aldridge, 2; Coates, 5; Stanley et al., 18). Professional training in FFP has been limited with evidence of a skills deficit in practice, and parents can find it difficult engaging with services because of their mental health and associated fear, stigma and shame (Cowling & Garrett, 7; Grant et al., 11).

The Northern Ireland Think Family initiative represents a strategic effort to promote FFP within adult mental health and children's services, in order to improve collaborative working and information-sharing to help families achieve greater access to early intervention and family support services (Donaghy, 9). Think Family has resulted in a range of regional and local initiatives to improve assessment, planning and intervention. These include: the development of a joint protocol to provide clear guidance on service response and promote interagency collaboration; the revision of adult mental health screening and assessment tools; specialised training; and the introduction of Think Family Champions to promote joint working across services (Falkov, 10). Specialist Think Family social work roles have been created to work alongside established Hidden Harm social workers, providing support for parents and families with dual mental health and substance use problems.

METHODS

The Health and Social Care Board in Northern Ireland commissioned an audit of social work case files from across service teams to establish whether Think Family Northern Ireland (Think Family NI) and FFP have become embedded across three different services (Community Mental Health Teams (CMHTs), and addictions and children's services). The audit sought to: identify the extent to which these services co-worked to support families; highlight good practice; and identify areas for improvement.

A random sample of files was selected from the three services in four of the five Health and Social Care Trusts, the main statutory provider of services in Northern Ireland. One Trust declined to participate because of current workforce pressures.

Sampling

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

- a parent;
- file opened within the last 12 months;
- a mental health problem and/or substance use problem that has/had a significant and enduring impact on social and personal functioning;
- past or present support from CMHTs/addictions services; and
- past or present support from children's services.

Although ethical approval was not required for an audit of current service provision, we received approval from Research Governance within each participating Trust. Data were processed under General Data Protection Regulation, article 6 (1) (e) (Data Protection Act, 2018). Electronic records and paper files were made available, and data were collected onsite, encrypted and securely transferred to the university network.

Data were collected from 108 case files. The COVID-19 lockdown ended fieldwork prematurely and electronic data from some files were unavailable (n = 12). Ten files were linked during data collection and analysed as a family unit (five files from adult services matched with five files from children's services), resulting in a final sample of 103 families' case files. Cases were broadly representative across the three services: children's services (28%), addictions (38%) and CMHTs (34%). The files from children's services were exclusively from social work practitioners, while the CMHTs' and addictions services' files covered a range of disciplines including social workers, community psychiatric nurses and drug outreach workers.

Audit measure

The audit tool (see Appendix S1 in the online Supporting Information) developed for the study was based on the 'Adult and Children's Services Joint Protocol' (Health and Social Care Board, 12). The tool captured the key case characteristics including demographics, contact with the primary service and other agencies, parenting difficulties and actions taken to support the family. In addition, it looked for evidence of:

- parental and child involvement in the screening/assessment and care planning process;
- interagency contact;
- mental health issues being explained to the parent/child;
- use of Think Family NI resources/approaches; and
- FFP such as meetings with the family, psychoeducation and family-focused conversations.

Additional relevant qualitative data were also captured, where appropriate, to help contextualise some of the decision-making.

RESULTS

Case file profile

Of the 103 families in the final sample, the mother was the primary focus in 85 per cent of cases and, in total, parents had caring responsibilities for 258 children, the majority of whom were aged under 16 years. Cases were complex, with problematic substance use (50%) and personality disorder (16%) the most commonly reported difficulties. Most parents had significant co-morbidities (including self-harm/suicide attempts (32%) and anxiety/depression (13%) in the past 12 months). Histories of child sexual abuse, domestic violence and being in state care as a child were evident. Additional potential stressors were observed, and families were seven times more likely to live in the most deprived decile than the least deprived based on the 2017 Northern Ireland Multiple Index of Deprivation (Northern Ireland Statistics & Research Agency, 15).

The average length of service involvement was over six years ($M = 6.2$ years, $SD = 5.71$, range 3 months to 28 years) and many families were engaged with other statutory services. Seventy-five per cent had at least one child subject to child protection registration and 48.5 per cent had involvement with Looked-After Children Teams. Families were provided with support from a wide range of agencies such as Family Intervention or Family Support Teams, as well as through referrals to voluntary sector services, psychiatric or psychological services, or school-based services such as counselling services and Education Welfare. The average number of referrals per family was 11 ($M = 11.0$, $SD = 5.21$, range 2 to 26).

Evidence of FFP

Over half of the files examined showed evidence of joint working across services, with CMHTs being more likely to demonstrate collaboration than either children's services or addictions services (Table 1). Half of the case files also included Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments (the regional format for assessments in children's services), although very few files had a copy of the joint protocol ($n = 3$) and there was evidence of joint planning in only 18.5 per cent of cases. In 44.7 per cent of cases, there was evidence that practitioners had discussed the impact of mental health on parenting with parents.

Practitioners recorded details of family conversations (28.2% of case files), meetings with families (24.3%) and age-appropriate explanations to children (22.3%). Children's services were more likely to report family conversations and meetings, discussing the role of the child as a carer and engaging in age-appropriate conversations with children, than the other services. They reported more direct engagement with children on a one-to-one basis and their recording in case note files always included a section that detailed individual conversations with the child where appropriate – this was not routine in the other services.

In 17.5 per cent of case files, there was explicit reference to Think Family/Hidden Harm work, although only 2.9 per cent included specific Think Family resources within the file.

TABLE 1 Case file evidence of FFP (total cases 103)

	N	%
Interagency collaboration	55	53.4
UNOCINI (49 files)/joint protocol in file (3 files)	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

FFP = Family-focused practice; UNOCINI = Understanding the Needs of Children in Northern Ireland.

Qualitative findings

Administration

Recording practices varied greatly between services and it was clear that direct engagement with children and young people was routine practice in children's services only. Communication between services could be complicated and frustrating, and was hindered by different information technology systems used across Trusts that did not freely transfer information about service users. Onerous and inefficient administration systems also contributed to an already heavy workload with errors in information-sharing that could lead to key personnel missing important appointments such as child protection case conferences.

Professional expertise

Practitioners from addictions services and CMHTs were more likely to be working with families with very young children (1 to 4 years; 26% of children in both services). Although some of these children were no longer resident with the parent receiving care, family time facilitated through contact arrangements was often inadequate and disappointing for parent and child. This age group is potentially the most vulnerable, but it was unclear whether staff felt sufficiently equipped or supported to provide the right setting or have the skills or experience to engage with young children. Similarly, children's services were often dealing with parents with complex mental health problems and whether their professional knowledge extended to this area was uncertain. At times, evidence demonstrated a lack of insight into some mental health conditions/behaviours.

Measuring effectiveness

Many families were receiving a large number of interventions, but it was difficult to assess how useful or helpful these interventions were from the case file evidence. The sheer volume of referrals to additional support services was overwhelming for some families. Many external agencies were involved (and likely to be gathering their own metrics), but how these data were shared was difficult to tell from the files. Similarly, for those parents who found it difficult to engage with services, reasons for disengagement were not well explained and families were at risk of being discharged from services for 'treatment refusal'.

Professional tensions

Tensions were evident between services where decision-making focused on individual risk rather than considering the family as the unit of treatment and support, given any safeguarding concerns. Opportunities to de-escalate situations or prevent child protection measures were missed. Conflicts in decision-making were evident, including situations where

contact arrangements were reinstated or children were removed based on children's services assessments contrary to advice from, or without consultation with, the mental health key worker, potentially placing children at risk.

Qualitative evidence of FFP

Recording of open and honest conversations with children or life story books/drawings were included in files, allowing children to ask questions about a parent's mental health problems which helped to allay fears and provide reassurance about their own safety and stability. Some files had clear safety plans that could be swiftly engaged if a parent was unwell/using substances, helping (older) children create a sense of control and understanding about how to respond in these circumstances. Where a child was not ready to have contact with a parent, being able to articulate and discuss this with a professional was important; giving the child added reassurance that his or her absent parent was also receiving help and support. When a child did not want to engage with the social worker, alternative means of communication were used to try and help establish a relationship. This practice was typical of the specialist FFP Think Family Champions and Hidden Harm social workers.

DISCUSSION

It is clear from the audit that practitioners were dealing with complex cases with multiple issues and co-morbid conditions, as well as difficult and protracted patterns of service engagement; the majority of cases had some engagement with child protection and/or Looked-After Children teams, in addition to CMHT services and addictions services. Within this context, it was encouraging to note that in 44.7 per cent of cases, practitioners had routinely asked about parenting issues and considered the impact that parental mental health had on the wider family, especially children. Equally positive was the finding that over half of the files examined demonstrated evidence of interagency collaboration and alignment of procedures through the use of UNOCINI to assess the needs of children. This is an encouraging baseline to build from, although more work is clearly needed to make this more widespread, particularly in relation to children's services and addictions services, where examples of collaborative working were less evident. It was not clear from the case files how families were supported to navigate referrals to multiple services or how the effectiveness of these interventions were monitored.

Joint planning was only evident in 18.5 per cent of cases. Parent mental health and substance use problems are often episodic, but joint planning can be an effective way to avoid escalation and avert child protection crises. The fact that this was only seen in a minority of cases indicates that further work is needed to translate collaborative working into collaborative planning that takes account of the wider family needs, rather than just individual parents or children. As discussed, there can be tensions between the remit and priorities of child protection practitioners and other services, and this can have an impact on information-sharing and decision-making. Improved communication, mutual understanding and joint decision-making are key to avoiding these kinds of disagreements, ensuring that all partners are fully informed about the complex risks which can be associated with mental health problems, and potentially preventing unnecessary case escalation/de-escalation.

While the audit found evidence of practitioners encouraging family conversations, this tended to be more common in children's services than CMHT services and addictions services. In this respect, the setting for service user contact is important. CMHT services' and addictions services' appointments were routinely held within healthcare settings, removing the possibility to observe family and home life and the opportunity to build a relationship or develop a better understanding of the needs of the household. Although home visits are costly and may carry additional risks for some staff, incorporating some level of contact within a family setting arguably may promote more comprehensive assessment and greater FFP.

Staff from children's services were more likely to demonstrate evidence of, and engagement in, age-appropriate conversations with children and meetings than staff from either CMHTs or addictions services. While this may be linked to variations in the child age group that the different services dealt with, it does have implications for how messages and conversations take place with differently aged children, and how confident staff are when communicating (messages and conversations) with children. Dedicated Hidden Harm social workers, who have a specific focus on working with the whole family, as well as some Think Family Champions were able to clearly demonstrate FFP with case files that included copies of 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, and providing opportunities for all practitioners, regardless of service setting, to develop these skills will be essential in improving support for families. Opportunities to promote interagency collaboration and foster joint decision-making could involve providing clear job descriptions, co-locating services, joint home visits and interprofessional education and training.

STUDY LIMITATIONS

It is important to recognise the methodological limitations of this audit and while additional information was drawn from records including phone calls, letters and other correspondence, not all FFP will have been recorded in practitioner files.

CONCLUSION

This case file audit has reinforced the complexity of needs that the different services are trying to respond to. While identifying important examples of positive, family focused, collaborative work, it also highlights a clear need to continue to actively address the barriers to joint working and to further promote FFP. Having the skills and experience to protect and support every family member when mental health problems are present is an important role for *all* services. Being able to rely on effective and efficient communication and recording systems can help support informed, complex decision-making and optimise the available support services that can safeguard children and support families better.

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ORCID

Claire McCartan https://orcid.org/0000-0002-2341-9715
Gavin Davidson https://orcid.org/0000-0001-6003-0170
John Devaney https://orcid.org/0000-0001-8300-8339

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