

## Challenges in evaluating a 'Think child, think parent, think family' approach to adult mental health and children's services

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### Abstract

*The rise of evidence-informed policy-making has led to an increased demand for evidence of the effectiveness of interventions in health and social care. Experimental evaluation methodologies, such as randomised controlled trials (RCTs), are often considered to be the 'gold standard' in evaluating impact. However, there is growing recognition that the use of 'pure' experimental designs may not be possible or even desirable (Pawson & Tilley, 1997) for the evaluation of certain types of initiative.*

*This article discusses the implementation and evaluation of the Social Care Institute for Excellence (SCIE) guide on parental mental health and child welfare in ten sites in the UK, which is currently in its early stages. It suggests that the concept of a 'complex intervention' (MRC, 2008) is helpful in thinking about implementation of the guide in terms of allowing local flexibility, targeting multiple parts of the health and social care system and the range of possible outcomes of the work. In line with the principles of realist evaluation (Pawson & Tilley, 1997), a key role of the evaluation is to help further understand and map the intervention rather than simply to provide a summation of success or failure.*

**Keywords:** Evaluation, realist evaluation, complex intervention, parental mental health, child

### Introduction

The Social Care Institute for Excellence (SCIE) is an independent charity funded by the Department of Health and the devolved administrations in Wales and Northern Ireland. SCIE identifies and disseminates the knowledge base for good practice in all aspects of social care throughout the United Kingdom. SCIE also has an interest in promoting high standards in evidence production and use, and contributing to the debate on evidence-informed policy and practice.

In 2009, SCIE published *Think Child, Think Parent, Think Family: A Guide to Mental Health and Child Welfare*. The guide is based on reviews of the relevant evidence (Beresford *et al.*, 2008; Parker *et al.*, 2008; Stanley & Cox, 2009) and a practice enquiry carried out at five sites in England. The guide makes recommendations about how

services can better support families in which there is a parent with a mental health problem.

The guide defines 'parents with mental health problems' as those parents with a primary diagnosis or need, identified as a mental health problem. In the guide, the term 'children' is used to refer to all children 18 years or younger, some of whom will be young carers. SCIE's guide forms one of a suite of guidance and protocols in relation to families with complex needs which were promoted by the then Department for Children, Schools and Families (DCSF) and the Department of Health (DH). The guide is also supported by the Department of Health, Social Services and Personal Safety in Northern Ireland (DHSSPSNI).

SCIE is currently working with five sites in England and the five Health and Social Care

Trusts in Northern Ireland to implement the guide. An evaluation of the work is planned and is currently in the design phase.

### **A note on terminology**

The terms ‘Think child, think parent, think family’ and the shorthand ‘think family’ and ‘think family approach’ are used interchangeably in SCIE’s work and in this article. These terms denote a whole-family approach to service delivery, in this case in relation to mental health services. It is important to note that this work is related to, but distinct from, the former cross-governmental ‘Think Family’ initiative in local authorities.

### **Evaluation and complex interventions**

The question of ‘What works?’ lies at the heart of evidence-informed practice and policy-making in health and social care, yet is notoriously difficult to answer. Numerous evaluations seek to evidence the impact of particular programmes and interventions and inform whether these should continue or be replicated elsewhere. In many hierarchies of evidence the use of experimental evaluation designs such as randomised control trials is seen as the ‘gold standard’ for ascertaining impact. However, several authors have argued that, for many interventions, use of experimental evaluation designs may be inappropriate, and may not yield the information required by policy-makers (Pawson & Tilley, 1997; Fisher, 2002; Kazi, 2003).

For example, Pawson and Tilley (1997) argue that many social policy interventions are highly complex and vary depending on the context in which they are implemented. They argue that the local context, which would be regarded as a confounding factor in an experimental design, is, in fact, intrinsic to the manner in which a programme works and in determining its success or failure. They argue that greater attention must be paid in evaluation to

describing the contexts in, and mechanisms by, which a particular intervention operates. They term this ‘realistic’ and, later, ‘realist’ evaluation.

Taking this approach to evaluation changes the role of the evaluator in comparison to a traditional impact-focused approach. Traditionally, an evaluator may have judged, usually at the end of an intervention, whether or not the intervention has ‘worked’. Using the realist evaluation approach, her or his role is to describe ‘what works for whom in what circumstances and in what respects, and how?’ (Pawson & Tilley, 1997). The evaluator may therefore have a key role in helping to clarify or refine the original policy (Mackenzie *et al.*, 2007).

A related school of thought deals with the implementation and evaluation of complex interventions. Guidance provided by the Medical Research Council (MRC, 2000, 2008) conceptualises complex health interventions and their associated evaluation challenges. It has been used as a framework for evaluating public health interventions by a number of research groups including Mhairi Mackenzie and colleagues at the University of Glasgow (Mackenzie *et al.*, 2007; Mackenzie *et al.*, 2010). In the most recent guidance, complex interventions are defined by the MRC primarily as “interventions with several interacting components” (MRC, 2008, p.6). The guidance also suggests that a complex intervention may be ‘complex’ according to a number of dimensions, namely:

- *Number of and interactions between components within the experimental and control interventions;*
- *Number and difficulty of behaviours required by those delivering or receiving the intervention;*
- *Number of groups or organisational levels targeted by the intervention;*
- *Number and variability of outcomes;*

- Degree of flexibility or tailoring of the intervention permitted. (MRC, 2008, p.7)

In common with proponents of realist evaluation, the MRC guidance therefore emphasises the need to investigate "... how the intervention works, in other words, what are the active ingredients within the intervention and how are they exerting their effect" (p.7).

Earlier guidance on complex interventions (MRC, 2000) emphasised that evaluation activities should be sequential – building up from theoretical and modelling/exploratory work to the development of RCTs and then long-term implementation. Although the emphasis on progressing towards the use of RCT study designs is lessened in the new guidance, the notion of different stages in understanding and evaluating an intervention is a helpful one.

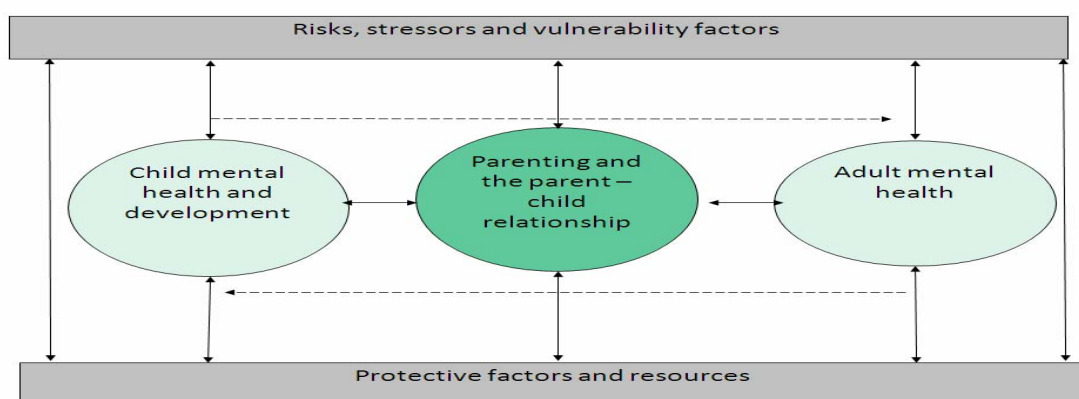
### 'Think family' approaches to parental mental health and child welfare

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

- Parental mental health problems can adversely affect the development and, in some cases, the safety of children;
- Growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood;
- Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers. (Falkov, 1998, cited in SCIE, 2009)

The adverse impact of parental mental health on child welfare has been of particular concern to policy-makers. By no means all children whose parents have mental health problems will suffer adverse impacts. However, in some cases, parental mental ill health can lead to: adverse impact on children's emotional and cognitive development (Department for Education and Skills & Department of Health, 2004); increased likelihood of the child experiencing mental health problems themselves (Meltzer *et al.*, 2000); and, in a small number of extreme cases, fatal abuse or neglect (Royal College of Psychiatrists, 2002).

**Figure 1** The Family Model (Falkov, 1998)



Adapted from Falkov (1998)

The effects of parental mental ill health on children can arise in a number of ways. Smith (2004) posits two main ‘routes’ by which parental mental ill health can have an impact on children. She distinguishes between ‘direct’ impacts, which result from exposure to the parent’s symptoms, such as children becoming involved in or the targets of a parent’s delusional behaviour, and ‘indirect’ impacts arising from the disruption of parenting caused by mental ill health. Indirect impacts may involve the child being separated from a parent whilst they are in hospital; disruption to the parent’s ability to carry out parenting tasks; or the impact of other factors which are linked to the parent’s mental health problem such as separation and divorce, or poverty.

Despite the importance of the interaction between the mental health of the parent and the safety and welfare of the child, services tend to be structured around either the adult with the mental health problem or around the needs of children (Stanley & Cox, 2009). Adults’ and children’s services are frequently separated by the organisation within which they are located (e.g. NHS trust versus local authority), professional background of staff, policy and legislative imperatives, information and recording systems and organisational cultures. Practitioners may also be reluctant to work outside what they see as their professional boundaries (SCIE, 2009). The separation of adult mental health and children’s services along multiple dimensions can make it difficult for professionals to take a holistic view of family needs. This can mean that some of the family’s existing needs may be overlooked, even though they are already in contact with services. Opportunities for preventing problems from arising in the future may also be missed.

### **The ‘Think child, think parent, think family’ guide**

Prompted by our findings about the difficulties in supporting families where a

parent has a mental health problem, SCIE’s guide (SCIE, 2009) makes a number of recommendations about how services can take a ‘whole family’ perspective. This can involve changing both within- and inter-agency ways of working.

The guide makes specific recommendations in relation to what organisations, managers and practitioners need to do at each stage of a care pathway (screening, assessment, care planning, provision of care and review of care) in order to achieve a more holistic approach. For example, two ‘priority recommendations’ from the guide are as follows:

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

***Assessment** - All organisations need to adapt existing assessment and recording processes to take account of the whole family and train staff in their use. This means developing and implementing ‘family’ threshold criteria for access to services to take into account the individual **and** combined needs of parents, carers and children. Strategies for the management of joint cases should be recorded where the situation is complex or there is a high risk of poor outcomes for children and parents.*  
(SCIE, 2009, p.3)

### **Implementation and evaluation**

Whilst the need for effective inter-agency working between adult mental health and children’s services is widely accepted, achieving this in practice remains

challenging. As one of the reviews underpinning the guide states '... in the past much policy and guidance has relied on exhortations to collaborate rather than offering constructive mechanisms for doing so' (Stanley & Cox, 2009, p.5).

SCIE was, therefore, keen to undertake further work, following publication of the guide, looking in greater detail at *how* the recommendations of the guide might be implemented. In September 2009, a project team at SCIE began working with five sites in England and the five Health and Social Care Trusts in Northern Ireland to implement the guide and gather further learning about good practice and solutions to some of the barriers identified. The five English sites are those which participated in the practice enquiry.

In England, the implementation is being led in each site by a multi-agency steering group, typically comprising managers from adult mental health services, children's services and the voluntary sector. The steering groups are supported by a SCIE Practice Development Manager. In Northern Ireland, two full-time project managers are funded by the DHSSPS to lead the project at a regional level, supported by a project board and the SCIE Practice Development Manager for Northern Ireland. Work in each Health and Social Care Trust is led by a Project Locality Team, the chairs of which meet on a regular basis. Each English site has received £10,000 from the Department of Health to assist with some of the costs associated with the project. However, in general, this work will need to be accomplished using existing resources.

At the time of writing, each site is in the process of developing and signing off a 'local implementation plan', outlining how they will implement the recommendations of the guide. Each site will undertake a number of 'workstreams' to address different aspects of the guide. Specific

actions vary across sites, but commonly selected activities include:

- Development of a strategy to guide the work;
- Implementation of protocols for joint work between adult mental health and children's services staff;
- Training for staff, including joint training;
- Amendments to screening and assessment processes.

The implementation project will last initially for two years in England and three years in Northern Ireland.

An evaluation of the work is being conducted in parallel with the implementation. The aims of the evaluation are to:

- Capture and disseminate learning about **how** to implement the *Think child, think parent, think family* guide (process evaluation);
- Capture and disseminate learning about **early indications of impact** of implementing the guidance in a local area (impact evaluation).

The findings from the implementation and evaluation work will be used to produce more detailed advice for other sites about how to implement the guide, culminating in a revised version of the guide in early 2012.

### **'Think child, think parent, think family' as a complex intervention**

Designing an evaluation of the 'Think child, think parent, think family' implementation sites has proved challenging, particularly in terms of how to define and measure the impact of implementation. The MRC's concept of a complex intervention (MRC, 2008) has been useful in articulating some of these challenges and in positioning the role of the evaluation. In this section the implementation of the guide is discussed in

terms of three of the MRC ‘criteria’ for a complex intervention: local flexibility and tailoring, the number of groups targeted, and number and variability of outcomes.

### **Local flexibility and tailoring**

One of the criteria for a complex intervention suggested by the MRC is the ‘degree of flexibility or tailoring of the intervention permitted’, with a greater degree of flexibility/tailoring leading to greater complexity.

Early indications from SCIE’s work with the implementation sites suggested that there would be significant tailoring of the guide to suit local circumstances, for example implementing only parts of the guide or adopting slightly different mechanisms for implementation. Strictly speaking, SCIE has no power to ‘permit’ (to use the MRC’s phraseology) or not permit this tailoring: SCIE has no regulatory powers and all the sites are participating voluntarily in the project, with the aim of improving outcomes for their service users. All local implementation plans are being ‘signed off’ by SCIE to ensure that they adhere to the overall principles of the guide but a certain amount of variation will still occur. However, the SCIE project team thought that there were a number of benefits in recognising that sites would tailor and interpret the guide, and so did not try to persuade sites to adopt a more uniform approach.

Firstly, the sites differ in terms of the extent to which local ways of working already reflect ‘think family’ principles. Locally tailored plans can, therefore, take account of the existing context in a particular area. Secondly, allowing local tailoring has enabled the sites to link the implementation to local priorities, for example existing Family Mental Health strategies or action plans arising from Serious Case Reviews. The early experience of the sites suggests that making links with existing local

priorities can be a useful mechanism of ensuring that the work takes place in the absence of a statutory requirement to do so. Thirdly, a key function of the project is to gather knowledge about how to implement the guide, and to harness local skills and expertise in doing so. If SCIE had been too directive in guiding the implementation, this element of the work would have been jeopardised.

### **What are the implications of this for evaluation?**

In some ways, local tailoring of the guide posed a problem in terms of defining the subject of the evaluation. It cannot be said that we are evaluating the impact of the guide because the guide is being ‘filtered through’ and interpreted by the local areas to a significant extent. In fact, we are evaluating the sites’ implementation of the guide which, whilst operating within the overall principles of the guide, may bear a greater or lesser resemblance to the ‘letter’ of the recommendations.

However, by recognising that tailoring and interpretation is taking place, this variation can be built in to the design of the evaluation. In line with the principles of realist evaluation, explicit recognition of local contextual factors and interpretation allows these to become objects of investigation for the evaluation, rather than inconvenient confounding factors, as they could be in an experimental design (Pawson & Tilley, 1997). An important part of this evaluation will, therefore, be to map and understand local variations in implementation.

### **Targeting multiple parts of ‘the system’**

Another of the criteria for a complex intervention set out by the MRC is ‘the number of groups or organisational levels targeted by an intervention’. The ‘Think child, think parent, think family’ guide meets this in two ways. First, the guide

explicitly makes recommendations focusing on different levels of an organisation – organisational (strategic), managerial and practitioner/clinician. Second, and as has posed a greater challenge for implementation and evaluation, the guide is applicable to a number of different services within the health and social care system. This, in turn, means that the guide is applicable to a number of different groups, both of staff and service users. This second aspect of complexity is discussed in more detail below.

The guide makes recommendations for “staff in mental health and children’s services from all sectors” (SCIE, 2009, p.1). Particular teams or staff groups are intentionally not specified within the guide: it was SCIE’s intention that this guide be widely applicable across the sector and the specific inclusion of some teams or staff groups could be taken to imply exclusion of other groups. However, neither mental health nor children’s services are monolithic, but comprise a set of services designed to meet differing levels and types of need. The implementation of the guide can, therefore, potentially entail targeting a number of different agencies and groups within the health and social care system.

For example, the *Every Child Matters* Green Paper (HM Government, 2003) set out three main levels within children’s services:

- Universal services for children and families (e.g. health visitors, schools);
- Targeted services for families with complex problems (e.g. children’s social care); children and families with identified needs (e.g. disabled children) or those in targeted areas (e.g. Sure Start);
- Specialist services for children at high risk (e.g. child protection services).

Service levels within mental health services are less clearly defined in government policy. However, the following five-level

framework has been suggested to support mental health commissioners (Haselgrove & Tibbles, 2005):

- **Level 0** – self care and support from family and friends;
- **Level 1** – primary mental health care;
- **Level 2** – community residential, day and home-based services providing a range of short term interventions for common mental health problems and recovery-orientated services for people with longer term needs;
- **Level 3** – emergency and acute care, including acute inpatient care and crisis resolution and home treatment;
- **Level 4** – highly specialised ‘low volume, high cost’ services such as for people who offend, those who need medium to long-term secure settings and people with complex and severe eating disorders.

The issue of ‘think family’ in relation to parental mental health problems is relevant to services at all levels of both adult mental health and children’s services, although it may be of greater relevance in some areas than others. Full implementation of a ‘think family’ approach to parental mental health and child welfare in a local area is likely to require some consideration of all these service areas, although localities may choose to prioritise particular services first. It is also important to note that, depending on the needs of the family as a whole, different levels of the two systems may be interacting with each other. The specifics of what constitutes effective inter-agency working - or the implementation of a ‘Think child, think parent, think family’ approach - will differ in each of these cases. Different groups of staff and service users will be involved depending on which part of this system is targeted.

**A range of outcomes**

The ‘think family’ approach can be applied to a number of different services within children’s and adult mental health services. A corollary of this is that what constitutes a good outcome will vary in different settings. We distinguish here between short-/medium-term outcomes (relating mainly to the way in which services are delivered) and long-term outcomes (relating to outcomes for service users). Three examples are given below of different service interfaces, as illustrated in Figure 2, and what may constitute a ‘think family’ response at each of these interfaces. Some possible short- to medium-term outcome measures are discussed.

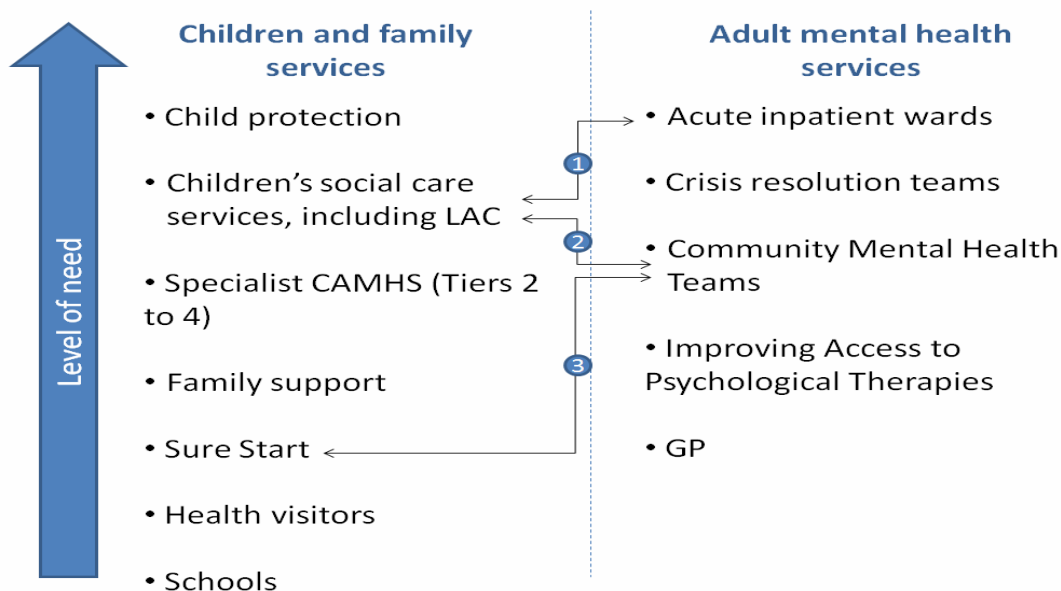
Potential long-term outcomes for service users in terms of mental health, family functioning educational attainment (for children) and so on are not discussed here. Much as a ‘think family’ approach must be differentiated for different types of services, it must again be differentiated for service users with different types of needs, although this is beyond the scope of this article.

**Example 1: Links between children’s social care and psychiatric inpatient provision**

The admission of a parent to psychiatric hospital can have a number of impacts on children and young people, including a different person caring for them or having to move house (Hawes & Cottrell, 1999). In some cases, admission of a parent can lead to children and young people entering the care of the local authority (Scott *et al.*, 2007). In the instance of a parent being admitted to psychiatric hospital, where a child is already known to social care, elements of a ‘think family’ approach could include:

- Where possible, early liaison between adult mental health and children’s social care services to highlight that a parent may need to be admitted and to explore options for the child’s accommodation, in consultation with the parent;

**Figure 2** Adult mental health and children’s services interface





- Assessment of whether ongoing contact with the parent is in the best interests of the child or young person in consultation with both the parent and young person (National Institute for Mental Health in England, 2004), and in line with the local protocol relating to child visits to psychiatric hospitals;
- Hospitals providing appropriate spaces for this contact to take place, such as designated 'Family Rooms' (Barnardo's, 2009);
- Continued use of the Care Programme Approach and care co-ordination whilst in hospital to ensure that arrangements for discharge, including the person's needs as a parent, are considered from the beginning (Department of Health, 2008);
- Use of the pre-discharge planning meeting to ensure that the needs of both the adult and child are met (Royal College of Psychiatrists, 2002).

In this case, possible short- to medium-term outcome measures that a 'think family' approach is being taken might include:

- Increased numbers of mental health facilities with family rooms;
- Increased appropriate and supported contact between parents in psychiatric hospital and their children;
- Reducing numbers of emergency admissions to local authority care of children of mentally ill parents.

***Example 2: Interface between a community mental health team and children's social care***

Children's social care services will not need to be involved within all families in which there is a parent with a mental health problem (Stanley & Cox, 2009). However, where parental mental ill health, which is being managed in a community setting, is having an adverse impact on family functioning, children's social care services

may need to become involved. The following example suggests how a 'think family' approach could work in this case:

- If an adult is referred to community-based mental health services, the adult mental health worker ascertains at an early stage whether the person has parenting responsibilities.
- The worker is then vigilant for any negative impact of the parent's mental health problem on their child or children, including direct and indirect impacts (Smith, 2004), and for signs that the person may need support in their role as a parent. Achieving this may involve visiting the parent at times when the children will be around and talking openly with the parent about the impact of being a parent on their mental health, and any support needs they have.
- If there are concerns about, for example, the child's wellbeing and development, the adult mental health worker discusses this with the parent and makes a referral to children's social care, and may undertake joint assessment with a children's social worker if appropriate.
- If the adult mental health worker's concerns are confirmed, but there are no concerns of significant harm, ongoing co-ordination with children's social care services would be required to ensure a joined-up service. As there are no concerns of significant harm, parental consent would need to be obtained for information sharing between the two services (HM Government, 2008).
- The adult mental health worker may wish to inform children's social care of any deterioration in the parent's mental health, changes to medication and so on which could affect the child. It may also be helpful for the child's social worker to provide information about the children which could have a negative impact on the parent's mental

health, such as displaying violence or behavioural problems (Falkov, 1998).

In this case, possible short- to medium-term outcome measures that a ‘think family’ approach is being taken might include:

- Increased number of appropriate referrals from adult social care to children’s social care and vice versa;
- Increased number of joint assessments undertaken in complex situations;
- Improved communication between adult mental health and children’s services staff – for example, through attendance of the adult mental health practitioner at Team Around the Child meetings or children’s social care staff at Care Programme Approach reviews and young carers’ reviews.

***Example 3: Interface between a community mental health team and preventative services such as Sure Start Children’s Centres***

Sure Start children’s centres (based on the original Sure Start Local Programmes, or SSLPs) are described by government as ‘service hubs’ providing integrated services to children under five and their families. Whilst many Sure Start programmes provide services to support mental health, such as counselling and anger management services (Barlow *et al.*, 2007) and screening for postnatal depression (Kurtz *et al.*, 2005), evidence suggests that supporting parents with existing or more severe mental health problems has been a challenge for the programmes (Garbers *et al.*, 2006).

Building on the existing ‘think family’ approach to mental health in children’s centres may, therefore, involve improving relationships and communication with local primary and secondary mental health services, and there is evidence that this has already started to occur within the programmes (Pinney *et al.*, 2007). A good example of this is the secondment of staff

from adult mental health teams to work within Children’s Centres (as is currently being undertaken in two of the SCIE implementation sites).

In this case, possible short- to medium-term outcome measures that a ‘think family’ approach is being taken might include:

- Increased number of parents with existing diagnosed mental health problems being supported by Sure Start centres;
- Increased number of appropriate referrals from Sure Start to relevant primary or secondary mental health services.

**What are the implications of this for evaluation?**

The preceding two sections have highlighted that the ‘think family’ approach to parental mental health and child welfare can be applied to different parts of both the adult mental health and children’s service systems, and that one would expect different short- to medium-term outcomes in each case. The implication of this is that there is no single outcome nor set of outcomes that the evaluation can measure to determine the ‘success’ or ‘failure’ of implementation.

Rather, the evaluation will aim to describe and investigate further the different ways in which the ‘think family’ approach is applied using a case study approach. The evaluation will focus on one or two ‘workstreams’ in each site, and investigate these in detail through qualitative research with various stakeholders, including the ‘workstream lead’, managers, practitioners and service users, and examination of relevant performance measures, as agreed in consultation with the workstream lead.

It is hoped that the case studies will allow a greater understanding of when different outcomes are applicable and why. In realist evaluation terminology, these are known as

'outcome patterns'. In line with the MRC's recommendation of an incremental approach to evaluation (MRC, 2000), these case studies should allow more specific hypotheses to be generated in terms of the impact of the approach on processes and practice, and on outcomes for service users.

## Conclusion

There is increasing recognition from a variety of quarters that 'pure' experimental approaches to impact evaluation are not always possible, or desirable (Pawson & Tilley, 1997; Fisher, 2002; Kazi, 2003). Approaches such as realist evaluation and the MRC's guidance provide a useful way to conceptualise and evaluate impact of complex interventions in health and social care. By using these frameworks to guide the evaluation of the 'Think child, think parent, think family' implementation project we hope to gain further information about *how* this approach may work and achieve outcomes, rather than provide a summation of success or failure.

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## Notes on Contributor

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