Partnership for Change – Phase 1 findings

Background

In 2019/20, UK referrals to child mental health services rose by 35%, yet access to treatment only rose by 4%(1). Children with psychiatric diagnoses incur more than four times the health and social care costs of children without(2) and, if children are placed in care, these costs multiply(3, 4). Providing support sooner is right for the child, family, and society(5). Our literature review (which is currently being updated) found no previous trial evidence for programmes aiming to prevent child maltreatment. However, relationship-focussed interventions do show promise, especially if involving child protection services(6). A study of an intervention incorporating these elements would be timely, especially in the encouraging current policy landscape(7, 8). Such a study, called Partnership for Change, was developed by a partnership between parents whose children have a social worker, charities, scientists, and health and social care professionals. It builds on our ongoing NIHR-funded Best Services Trial (BeST?, PHR: 12/211/54), by adapting our existing Infant and Family Team (IFTs) (the Glasgow Infant and Family Team; GIFT, and the London Infant and Family Team; LIFT) to form Infant Parent Support (IPS) teams, to address the problem of poor mental health in children who have a social worker and reduce the risk of children coming into care.

In BeST?, those families randomised to IFT intervention received an intensive multidisciplinary attachment-based assessment, then a tailored intervention using evidence-based therapies that focus on the parent-child relationship(10). Although BeST? will not report its quantitative findings until 2024, both IFTs have maintained stable staff groups over several years and are perceived as bringing greater influence to decision-making due to their depth of focus, provision of a trial of treatment for the family and objectivity(11). This builds on promising research findings from New Orleans, US, where the model from the IFTs originated, which suggested improved safety of subsequent children(12) and the child's mental health in the longer term(13). However, it has been challenging to deliver the IFT model within the highly structured parameters of the legal system (11). We have frequently been asked why we are not delivering IFT much earlier in the family's development – well before care proceedings, or even before child protection proceedings, are required. Intervening to support parents in building family resilience *before* a crisis precipitates accommodation - with emphasis on understanding, respect, reducing stressors and improving resilience - gives families much greater opportunity for change(14). Focusing on families at this earlier stage chimes well with current social care(7, 9) and judicial(15) policy nationally. The English Care Review Case for Change states that "too often we are allowing situations to escalate and then being forced to intervene too late, severing children's relationships and setting them on a worse trajectory"(page 10)(16). The Scottish Care Review (also known as The Promise) concluded that "where children are safe in their families and feel loved they must stay – and families must be given the support together to nurture that love and overcome the difficulties which get in the way" (page 9)(8).

All UK children in need of mental health services face challenges accessing them in the wake of a recent massive rise in referrals(1), but children from ethnic minorities or those with a disability wait the longest (page 50)(1). Parents of children with neurodevelopmental conditions (NDCs), such as Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD) and Intellectual Disability(ID), often experience a high level of stress(17). NDCs are not mental health problems - they can confer strengths as well as emotional and social challenges(17) – but, if stressed, family relationships can deteriorate, and both parents and children are likely to suffer a worsening of their mental health(18). A lack of support for parents if the child has a disability can further increase parental stress(19), increasing the risk of the parent developing entrenched psychiatric disorder and/or substance misuse(20). Often, when families have asked for help, the response has

been a child protection investigation rather than referral for treatment or support(1), and judgements about parenting capacity are usually not based on validated assessments(21).

Parents whose children have a social worker have typically also experienced multiple adversities in their own childhoods(22). Socioeconomic factors, such as low household income and parental unemployment, undoubtedly increase parental stress and are associated with poorer child mental health(23). There is often a failure to address major challenges in material circumstances(24), such as inadequate housing(25), and little therapeutic support is offered to improve family wellbeing(26). Extreme parental stress is a key risk factor for child abuse and neglect(27) which is likely to worsen any child mental health/behavioural problems(28). A vicious cycle can ensue in which the child is eventually taken into care, and this can sometimes become an entrenched multigenerational pattern (page 51)(16) that indicates a “spiral of failure” on the part of services(29).

Yet recent research suggests that, in many cases, this kind of vicious cycle could have been prevented if intervention had been provided for the family much earlier in this process(30). Short, focussed interventions can greatly improve parental sensitivity if offered soon enough in a child’s life(31). Children whose parents were supported enough to be able to provide the most sensitive care in the early years incur less than a thirteenth of the lifetime costs (including family expenditure and costs of health, education and social care and justice services) compared to children whose parents provided the least sensitive care (32).

Maltreatment (i.e. child abuse and neglect) and subsequent care placement is profoundly costly for the children involved(2) and for their families (3). It is also profoundly costly for society(33): children with psychiatric diagnoses incur more than four times the health and social care costs compared to children who do not have a psychiatric diagnosis(2) and, if children are placed in care, these costs multiply(3, 4) - yet there are wide cost variations across the UK(4). “It costs more to place a child in the care of a local authority than it does to send a child to a top boarding school”(4). For over a decade, the number of children on child protection plans or in care in England has grown year-on-year(29), highest in local authorities where there are high levels of social deprivation and where local authorities have been rated as inadequate or needing improvement(24). In Scotland, there has been a year-on-year reduction in the number of children coming into care(34), so upward trends are not inevitable.

New multi-agency systems to build resilience in struggling families are urgently required. Previous attempts to develop effective interventions to reduce maltreatment in high-risk families have largely failed(35). We therefore propose to develop and test a new service called Infant Parent Support (IPS). What follows is a report on the Phase 1 findings, and it describes both the coproduction of IPS and a qualitative examination of relevant stakeholder views of the way IPS might function in practice.

Methods:

Coproduction

Two groups of Parent Collaborators (PCs) (initially ten in total) whose children have a social worker worked with professionals from existing Infant Mental Health Teams and researchers to co-produce Infant Parent Support. Parent Collaborators are parents who, at some time in their life, have had a child who had a social worker. The group of PCs who took part in Phase 1 have experienced a range of difficulties that have resulted in their child or children having a social worker, including addictions, adult mental health problems or neurodevelopmental conditions in an adult or child in the family. All had experienced poverty. PCs were recruited through a mixture of leafleting of community organisations in Glasgow or Bromley and social media posts. Every effort was made to reach both male and female parents and a range of ethnic groups, however the parents who agreed to take part were all white and female. PCs were reimbursed according to NIHR Involve rates for attendance at

meetings, preparation time and travel. They were supported, both during meetings and in individual debriefing sessions, by and expert-by-experience co-investigator and research assistant PC Coordinator, Sharon Graham who had, herself, had a child with social work involvement and who has extensive experience of family support and advocacy work.

Although the initial intention had been to involve IFT clinicians and practitioners in small meetings hosted by PCs, this was not possible because a. the PC Coordinator was only employed 1 day/week which was not sufficient time to conduct all of the face-to-face individual meetings that would have been required and b. the entire IFT teams needed to understand the change required to develop IPS from IFT. We therefore set up a system of bi-monthly Development Days (held alternately in Glasgow and London) attended by both IFT teams, both groups of PCs and the research team. A series of working groups - (Poverty aware working group, Neurodiversity working group, Neurodiversity task and finish group, Assessment and Intervention working group, Leaflet planning group, Interview planning group, Parent collaborator/Lift collaboration) were convened to discuss individual issues and each involved members of both IFT and Parent Collaborators. The PC Coordinator's time was increased to two days/week six months into the study.

Stakeholder consultation

Fifteen interviews and five focus groups with stakeholders from health and social care services were conducted in order to understand the service landscape that parents whose child has a social worker have to navigate and to contribute to the coproduction. Four research questions (RQs) guided the consultation and topic guides were prepared to reflect these:

RQ1: Can the IPS intervention be coproduced from our existing IFTs with the input of parents and professionals?

RQ2: Are care pathways between child and adult health and social services adequate to ensure safe delivery of IPS (i.e., sufficient multi-agency communication and planning to ensure child safety) in the contrasting legal/social care contexts of Glasgow and London?

RQ3: What are struggling families' experiences of, and barriers/access to, mental health services?

RQ4: What is the profile of services-as-usual (SAU) (including infant/adult mental health; social care statutory processes) at each site and can care pathways be improved?

Thematic analysis

The research team followed a pragmatic approach to the development of an initial coding framework structured to reflect the broad study aims and topics covered in the interview topic guides. Data were then thematically analysed using Braun and Clarke's suggested 6 steps to Thematic Analysis. Data were imported and managed in NVivo12 Qualitative Data Analysis software. The flexibility of applying this approach to the qualitative analysis aided researcher familiarisation with the data, by engaging fully with all interview recordings and transcripts (step 1); the process of coding then started (step 2); codes were refined and considered, and then developed and grouped into potential wider themes (step 3); themes were then systematically reviewed and reflected on to ensure reliability and validity to the analysis (step 4); themes were then defined (step 5); and qualitatively contextualised, interpreted and written up in report format (step 6).

Using this stepped approach to the thematic analysis enabled initial consideration of individual and group stakeholder narratives and their nuanced experiences, while contextualising wider sample experiences, similarities, and differences in relation to access to health and social care services and other system support identified and discussed during qualitative interviews. The iterative and reflexive analysis was supported by regular discussions with the wider research team. Regular dialogue about research findings with trial

colleagues (including study stakeholders) ensured a consistent approach to data analysis, reduced the likelihood of researcher bias, and maintained fidelity to research aims and objectives. Please note that certain quotes are identifiable and this document will be shared internally to ensure any identifiable practitioners are willing for these quotes to be shared before any submission to academic journals or other public dissemination.

Sample characteristics

Participants	**Type of Interview**	**Area**
Parent Collaborator Coordinator	1 to 1*	Glasgow
Parent Collaborator	1 to 1 X3 1 to 1 X2	Bromley Glasgow
London Infant and Family Team	Focus Group (4 participants)	Bromley
Head of Safeguarding and Care Planning	1 to 1 interview	Bromley
Drug &Alcohol Service Safeguarding Lead	1 to 1 interview	Bromley
Drug & Alcohol Service Manager and Keyworker	Dyad interview	Bromley
Co-occurring Mental Health & Alcohol and Drugs Lead	1 to 1 interview	Bromley
Health Visitor Lead	1 to 1 interview	Bromley
Glasgow Infant and Family Team 1	Focus Group (3 participants)	Glasgow
Glasgow Infant and Family Team 2	Focus Group (7 participants)	Glasgow
Glasgow Health Visitors (incl. 1 Team Lead)	Focus Group (3 participants)	Glasgow
CAMH Neurodevelopmental Conditions Lead	1 to 1 interview	Glasgow
Local Authority Social Worker Children and Families Senior Leads	Focus Group (3 participants)	Glasgow
Adult Mental Health Psychiatrist & Strategic Lead	1 to 1 interview	Glasgow
Drug, Alcohol & Parenting Clinical Psychologist Lead	1 to 1 interview	Glasgow
Total	**20**	

*Two interviews have been carried out with the Parent Collaborator Team Lead, one at 3 months into the study and one at 7 months into Phase 1. Minutes of PC meetings have also been analysed.

The views of 35 stakeholders were gathered during the 20 one to one, dyad and focus group interviews. Thirty-one participants identified as female and 4 as male.

Results

We have organised the presentation of the findings as follows: for each research question (RQ), there is a brief overview of key themes and headline findings, then a more detailed overview of the findings.

RQ1: Can the IPS intervention be coproduced from our existing IFTs with the input of parents and professionals?

Themes: "*Equity", "time" and "complex administrative systems" (Additional themes and detail relating to PC experiences are reported in an attached addendum)*

Headline: Achieving genuine co-production in Phase 1 has been central to the process and, in general, has been successful. The study timeline initially anticipated this would take 6 months. However due to a number of complexities (including research team recruitment; PC recruitment, involvement and needs; multiple stakeholder involvement across services; meeting coordination; the need to reduce power imbalances where possible, and the inception and setting up of a number of specific IPS service design working groups) the

process has taken 10 months and is ongoing. Several strands of the co-production will continue in Phase 2.

Overview: The PC Research Lead has been interviewed to explore experiences of co-production at 2 points during Phase 1 to inform our understanding of co-production in practice. Content has included barriers and facilitators to this process and practical issues impacting on their own workloads, PC and project timelines. The PC Coordinator has coordinated and supported the involvement of the 2 teams of PC (1 in Glasgow, 1 in Bromley) throughout in their overall project involvement and has supported individual PC team member involvement in IPS service design working groups.

A key facilitator to supporting PC involvement has been offering supportive flexibility to Parent Collaborators. Their involvement has been in a voluntary capacity and changes in personal circumstances have been understood, respected, and supported to enable individual longer-term commitment to the study.

> "I've always…kept in touch with [name], we've always had that connection that's what has kept it going really, otherwise I probably would have left a long time ago."
>
> PC1

> (Researcher: "…do you feel that you've been supported enough to be involved with Partnership for Change?) PC2: Oh, yes, definitely, because you listen to the conversation, you listen to the questions, you listen to all the little stories that they had, and it's marvellous…"
>
> PC2

> "…being nice, being respectful, there's been no judgment, and she's been really supportive, it really has helped a lot, just checking in with me, and making sure I'm alright, it's been really nice."
>
> PC3

This facilitative approach has taken time. The time required to coordinate meetings, tasks, volume of requests for input, and then to negotiate IPS service developments in an inclusive way has increased the PC research lead's workload significantly.

This was not initially envisaged, and with sole responsibility for PC involvement, the PC Coordinator's hours had to be increased and the volume of work involved has negatively impacted on their capacity to take annual leave.

There have also been practical difficulties with active PC involvement; these have included ongoing ethical approval delays due to coproduction approaches not fitting with established and standardised organisational and institutional ethical processes. This disconnect has hampered how Phase 1 has progressed in terms of supporting PCs active involvement in the research element of this complex intervention. This was unforeseen.

Payment of expenses and access to digital support to attend meetings remotely have taken time to organise, secure and distribute mainly due to slow university systems. This has been a hinderance rather than a barrier but if the experience was to be repeated speedier university systems would facilitate active involvement of PCs sooner in the process.

Parent Collaborator Involvement

There has been goodwill, understanding, and commitment to the process and purpose from PC groups in both areas from the beginning of recruitment. Parents recognised and endorsed the need for earlier, non-stigmatising support for families facing multiple adversities (including practical support including WR advice).

> "I'd had 10 year of social work experience I felt quite passionately about, do you know what I mean, making the experience a bit better [for others], well no' that I've, I've had good and bad experiences with services…but I just, I felt passionate about trying to just help. I used to think that some workers, um, they just kind of read it out a book and didn't really understand…the different thoughts and feelings that the parent might have around it [their situation]. So, aye it's been good, I've really enjoyed it, I've learned a lot as well."
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> PC3

Initially, 5 PCs were recruited in both areas, however 2 parents have since withdrawn from Bromley and 3 from Glasgow. There are currently 5 parents in total contributing to intervention development groups on service design, NDCs, assessments and poverty awareness (Poverty aware working group, Neurodiversity working group, Neurodiversity task and finish group, Assessment and Intervention working group, Leaflet planning group, Interview planning group, Parent collaborator/Lift collaboration group).

The ratio of professionals to PC has created in an imbalance in perspectives in favour of professionals involved and this has potentially slowed the process down due to resistance and sometimes a lack of professional understanding/buy-in to co-production as a model of service development.

> …because they're such big voices, you know, and the professionals have been working in this field for a long time, so they've kind of got an idea of where they see things going, which might not necessarily be a good way for IPS to work. So, I think, that's one of the biggest barriers so far.
>
> PC Research Lead

Service design components have been explored by PCs from initial meetings and PCs have committed to the evolving process, to attending development days and working groups to consider essential service components in more detail. PCs have experienced fear of self-disclosure in their involvement in Phase 1 and this highlights the importance of the need for one-to-one support to facilitate addressing perceptions of power imbalances to promote meaningful involvement, including the time needed to build trust between parents and professionals.

> …a couple of people have said to me, 'I don't really want to tell them too much still' because they're kind of still a wee bit sceptical about how far would I still, you know, end up with social work involvement if I'm telling stories and stuff…and it's took me quite a while to kind of try and break that barrier down…
>
> PC Research Lead

Collaborative Working

There have been additional tensions between organisations involved in the study regarding lengthy discussions around valuing the skill sets of lived-experience practitioners within a new IPS service, recruiting people at the right stage in their personal development, and in terms of offering appropriate support, salary, and grade. This has taken additional time and has not yet been resolved in a way that is satisfactory to all parties so will require further review and refinement during Phase 2. Carrying out assessments correctly and with empathy is a skilled role and the PC lead is concerned that being recruited in at a Grade 3 may be "setting people up to fail" as they may not have the skills to meet the post requirements.

Supporting PCs to feel comfortable with complex professional working approaches has also taken time. One PC offered their perspective on why more time would have been more beneficial to the process:

> (Researcher: "…now just thinking about, um, how it's been on Partnership for Change for you, is there anything that you would improve? And if so, how?) I would

> say just more time together, like all the different people all together, and it is hard because of the way it's happening, so it's either, like, on-line or grabbing a day here, or grabbing a day there, and it's, aye, just more time, it's the biggest thing because, like, the question before, relationships, you are building [stops], you are breaking down barriers and building trust, um, aye. (Researcher: With lived experience…) Yeah."
>
> PC4

Also, group emails, continual meeting requests, and short deadlines have meant that parents have had a lot to learn, respond to, and grapple with, in a short space of time. Professionals take these approaches for granted but approaches have had to be refined so that parents were included, supported and empowered to be properly involved in ways they felt comfortable working.

> "…they were getting way, way, way too many emails. So, they were losing out on going to meetings because they didn't know it was them or if it was… and you know when you've got a ton of threads from people …and it's all professionals and then, I mean, I can't understand them half the time, so they were getting really frustrated, the parent collaborators, so it was decided that the dates and stuff would come to me and the links, I would hand them out to the guys and then I would remind them a day or two before that it is going to be happening, so far that's been working, so."
>
> PC Research Lead

PCs have needed to flex in and out of coproduction processes due to work and home-life commitments. Being able to record all meetings, minute-taking and circulating links to meetings PCs have been unable to attend would have enabled increased understanding of the coproduction work undertaken at all stages of development as it progressed. A dedicated administrative lead taking minutes, ensuring meetings were recorded and circulating links and information could have addressed this unanticipated issue.

PCs feel they have benefited from one-to-one support received throughout Phase 1 which has been provided by the PC Research Lead. Establishing these supportive relationships has ensured that PCs have felt valued and involved. These relationships have also helped PCs understand the importance of their contributions, and their ability to see where their own personal growth has occurred.

Future similar projects would benefit from the PC Coordinator being employed full time in order to support greater PC involvement in coproduction.

In principle, the prospect of IPS team practitioners working alongside people with lived experience has generally been well received. How it will work in practice has been considered from both positive and negative perspectives and these data can be utilised moving forward into service planning to ensure the right boundaries, support and safeguarding are in place for all practitioners working within the new service. Parent collaborators recognised personal growth and learning reciprocity for themselves and practitioners during the coproduction process.

> "…It's been good, I feel like I've learned a lot, I feel like my confidence is definitely grew the longer we've been doing it and stuff, because, I think, when at first I thought, 'well, what can you learn off me?', but then when I heard the feedback from them, saying, 'oh, this really helped us, [name]' and 'oh, we've been thinking about this you said…' and stuff, it made [me] feel better and more confident to come in and…share my experience."

PC3

Moving forward, a consultant in co-production joined the most recent IPS service development day in order to continue to support PC and practitioners in their understanding and approach of effective co-production practices and approaches.

Co-production has facilitated the development of the IPS service to date. There has been a range of unanticipated factors that have slowed the process down. The process is not yet complete and will need to continue to be just as active throughout the feasibility randomised controlled trial which is about to begin.

Working alongside lived-experience colleagues is not a new concept in other specialist working environments including Drug and Alcohol and Adult Mental Health services. Key stakeholders from these services could contribute to future IPS developments if required.

Further attributes or systems that promote relationship building and practical support across services working with families can be found in Appendix 1.

RQ2: Are care pathways between child and adult health and social services adequate to ensure safe delivery of IPS (i.e., sufficient multi-agency communication and planning to ensure child safety) in the contrasting legal/social care contexts of Glasgow and London?

Themes: "*Complexity", "Relationships", and "Developing Systems"* [N.B. The barriers and facilitators identified in RQ2 also relate to RQ3]

Headline: In relation to IPS if the correct mechanisms are activated between appropriate referrers there is no reason why the safe delivery of IPS should not be possible. If there is focus on informing a range of practitioners and getting the service known before it is launched this has the potential to encourage appropriate referrals. Linking directly with GPs and early years educators could also inform this research question further. HVs could be conduits to IPS via SW if processes between services are agreed.

Health visitor and IFT stakeholders interviewed perceived social work (SW) thresholds as high and specifically focused on high levels of risk. This could be a potential barrier for IPS referrals from SW settings.

Overview: Existing pathways into adult and infant services are complex. Factors include systemic, service, and personal barriers and limitations [these are detailed in more detail in RQ3 findings]. Practitioner stakeholders recognised that no two parent and family journeys are the same. There can be multiple points of access or none, due to numerous factors which include personal reasons and service involvement/limitations.

Depending on which service practitioner stakeholders worked in, perceptions of how parent journeys progressed differed. Parent and child experience; service thresholds, service and practitioner responses, and mechanisms between services/multiple agencies all impact parent and child journeys into and out of services [this finding also informs RQ3].

> "… people do not always hear from SW again and problems can then escalate… it is at is that point parents could do with help, but they [parents] may also mask this."
>
> PC Meeting Minutes

Pathways to getting the right support for parents and children can be helped or hindered by these numerous factors.

Social Work

Glasgow

Social Work (SW) Health and Social Care Connect and the triage approach known as Children and Families Duty Teams (which includes the Early Help Team in the South) and wider support services in Glasgow could be potential mechanisms for referrals to IPS if SW triage staff are primed and ready for the IPS referral process.

Adult mental health SW systems in Glasgow link directly with Children & Family SW and Health and Social Care Connect in Glasgow offers a triage response and refers according to level of presenting/perceived need.

SW Children &Family Teams, Adult Mental Health Teams and the Children's Disability Teams could be safe pathways into Infant Parent Support (IPS), as could the Wee Minds Matter service (i.e. the NHS Greater Glasgow and Clyde Infant Mental Health Service) where practitioners might already be linked into SW services. The Autism Resource Centre could be another potential mechanism for IPS referrals if parent and child needs have been identified. SW leads in Glasgow have knowledge of and links with this service.

There are multiple routes that can potentially be taken by a parent entering into contact with SW services. Pathways are clear but a range of practitioners reported perceptions of high SW thresholds with an understanding that parent or child's access points are more likely to be at a point of crisis rather than at levels where preventive support would be more appropriate (please see mapping lists in Appendix 2).

> "I think, health services' thresholds have probably always been lower than social work services and I think there's a whole lot of factors in the mix there, but yeah I think there's the gaps there in terms of being able to respond, it's most urgent and the most severe child protection cases which will dominate and then on a social work case load, all the things that social workers are trained to and *want* to do is almost impossible for them to do any early intervention work that we would love, [noises of agreement], we hear this all the time from our area team colleagues, [noises of agreement] we would really love to be doing this work, but they are having to deal with crisis after crisis, after crisis, and that takes up all their time really."
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> GIFT Practitioner - FG2

As well as perceptions regarding SW thresholds there are numerous complex reasons why families' problems escalate to the point where practitioners perceive SW input would be required. These include personal issues where families may be experiencing fear of stigma, shame, do not have adequate support or are not equipped to access timely support when need is initially identified. This can lead to escalation of problems for families.

Additional gaps where there are perceptions regarding when SW involvement would be appropriate

Considering and accessing appropriate alternative sources of support for vulnerable families instead of SW was reported also to be problematic for some health service staff. This, in part, relates to current SW processes not being properly understood by a range of practitioners. Also, long waiting lists for alternative statutory and third sector potential supports and/or difficulty in accessing funding for families to access specific alternative support were also reported to be problematic for practitioners working in health.

> "…part of the challenge is, I can honestly say I struggle to understand and know enough about how other services work and how, especially, for example, child and family social work, work."
>
> MH Practitioner

GIFT practitioners reported there are also gaps in Children's Hearing System representatives understanding and knowledge of IMH needs (therefore perceptions of a gap for families who are likely to require support and may already have SW involvement).

Bromley

There are clear pathways into and out of services provided in Bromley. These are detailed in the Thresholds of Need Safeguarding Document and the quick guide. The document provides explicit information regarding the 4 levels of need, access routes to services, processes, information sharing, escalating concerns, etc. It is currently being updated and should be available imminently.

The Bromley Children and Families Hub (formerly known as the Multi Agency Safeguarding Hub (MASH)) was launched in March 2023 and has been set up as part of service restructuring, to streamline referral approaches where children and families may require additional support. The hub provides an initial screening service with the view to divert families to alternative interventions and support to prevent escalation and access to Tier 4 Social Work Safeguarding and Care Planning Services. Referrers to the hub include schools, GPs, HVs and the Police.

> "…we haven't really changed that in terms of the different…tiers, as it were, but the whole idea would be we'd think together about, you know, what's the presenting needs? How serious is it in terms of, is it an issue about safeguarding a child, or is it about trying to put in some early help or intervention services that could actually work with this family, and a lot of our work is actually pushed away, it's amazing how much is diverted."
>
> Senior SW Lead

Bromley also has a multiagency partnership called the Bromley Safeguarding Children Partnership and this includes the Bromley Council Early Intervention and Family Support Team, police, health and education staff, and the range of SW children's services.

The Bromley Children Project (BCP) is a borough wide service that delivers early intervention and family support to families living in Bromley through its six Children and Family Centres, a range of Parenting Courses and through Family Support and Parenting Practitioners (FSPP) offering 1:1 family support, where needed. BCP works closely with partner agencies such as Jobcentre Plus, and through signposting and multi-agency working to provide holistic support to all family members. BCP accept both professional and self-referrals. Families can also access BCP via the Children and Family Centres. If a child or family has needs considered to be in Tiers 1, 2 or 3 of the continuums of need, they can be referred to BCP.

Elements of positive and negative practice have been considered by D&A and AMH practitioners in relation to SW input with adults who are parents. HVs do work with SW in the area and do carry out joint home visits when necessary. Parent collaborators drew attention to the Phoenix Centre in Bromley which is a health-based resource with a direct focus on neurodevelopmental conditions for Children and their families. This could potentially be an

equivalent resource where families experiencing difficulties could be referred into IPS. This service works closely with health and social care services in this area.

Health Visiting Services

HVs reported working directly with families described their role in recognising vulnerabilities for families and referring on to a range of supports (statutory and voluntary) for parents and children aged 0-3 in Bromley and aged 0-5 in Glasgow. Regular, lengthy home visits are scheduled in Scotland according to the key stage process (see page 8 of embedded link) usually known as the Revised Universal Pathway. HV reported direct links and referrals to SW in both areas. HV services in both geographies utilise the support of interpreting services for the populations they work with.

Bromley
Bromley Health Visitors service offers a blend of home, practice, telephone and children's centre visits and assessments and work closely with GPs (particularly in geographic areas where multiple deprivation indicators are recognised). There are gaps in service provision due to staffing levels and contact with families (including parental opt out) in this area. HVs carry out routine monthly visits to Gypsy/Traveller site. School Nurses make opportunistic immunisation visits from time to time during these scheduled HV site visits. HVs in this area work with inappropriately housed, vulnerable families with complex needs.

Glasgow
HVs reported mixed experience of appropriateness and responsiveness from SW services in Glasgow. These mixed experiences are reported by both HVs and SW staff. This finding indicates tensions between HV and SW perceptions of appropriate and inappropriate referrals into SW services. Recent funding into third sector and wider universal services for children has been allocated to facilitate responses to prevent escalation of problems for families and this is ongoing. However, HV also noted that waiting lists across third sector and statutory services remain prohibitive when seeking additional support for families.

HVs and CAMHS staff reported that for vulnerable asylum seeker families and families from non-dominant cultures and ethnicities there are definite gaps and barriers to access, service understanding and responsiveness across some CAMHS, health visiting and face to face social work services.

A children's service lead carefully considered the need for developing more representative services in terms of non-dominant cultures and minoritised groups. They recognised this is an evolving process across health and social care services in Glasgow. There is a clear awareness that it's a huge agenda and work is currently ongoing to address this.

Home Office jurisdiction is an additional barrier for asylum seeking families. Also, these families' exposure to significant trauma was identified during interviews with health visitor stakeholders.

In geographic areas of multiple deprivation HVs recognised that staff from multiple agencies can become desensitised to the degree of hardship faced by families. This can impact on staff responses, resourcing and offers of timely and suitable support. HVs reported that strains on other services leaves them to "hold" families facing adversity as there is no immediate access to alternative support. Significant poverty and hardship were also discussed for families in the care of HV services across areas of multiple deprivation.

Staffing levels within HV services in Glasgow were also reported to not be functioning at capacity. Key reasons for this relate to post lockdown challenges including higher than usual rates of long-term sickness due to COVID and the demographics of the workforce.

Health and Social Care Partnerships (HSCPs) and other partnership working

In Glasgow, Health and Social Care Partnerships are the over-arching partnerships governing services. In Bromley, there is definite partnership between universal services,

including health, and non-statutory and statutory children's social care services but structures are not defined in the same way and function differently (reported above).

Partnerships between health and social care have the potential to enable the development of closer working relationships between a range of health and social care services, and tiers of service in terms of referral pathways generally, and for specific IPS referrals. Working practices in Bromley highlight this.

Drug and Alcohol Services

Practitioners in both areas perceived high levels of suspected neurodevelopmental conditions (e.g. Autism and ADHD) in adults accessing drug and alcohol services. Self-medication for ADHD was cited as a factor for people using/misusing stimulant substances. Adult neurodevelopmental assessment in this context is limited in both Glasgow and Bromley.

Bromley
There are Safeguarding and Co-occurring Mental Health Alcohol and Drug leads in D&A services in Bromley. The Co-MHAD position is carried out by a consultant nurse who directly supports adults (including parents) with co-occurring mental health and D&A difficulties. Their role also extends to supports services and practitioner developments within statutory AMH services and D&A services to provide a more joined up approach. The D&A service has a direct relationship with AMH tiers of servicer and involves crossover visits to AMH community and ward facilities as well. The D&A service has a direct relationship with SW, but practitioners reported that SW referrals do not always reflect client need. Practitioners questioned SWs skills and knowledge, and methods of assessment when referring people for D&A service input.

Criminal justice responses to adult alcohol and drug users were described as problematic for parents, including referrals to the Family Drug and Alcohol Court.

Glasgow
There is parental assertive outreach and parent assessments carried out in Addictions Services in Glasgow. Links between AMH and Addiction services continue to be problematic for parents in this area. AMH services and addiction services in Glasgow still operate as separate bodies. This causes ongoing difficulties for adults (including parents) who require input from both services. Addiction services therapeutic support is not as well-resourced as AMH services, and this disconnect between the two services can lengthen journeys for parents with addictions who are impacted by poor mental health and histories of trauma. SW are not always equipped to understand the impact of trauma on adults and for parents this can result in unrealistic expectations of what parents can achieve in terms of recovery and parenting. This may negatively impact on safe routes into IPS for parents.

Adult Mental Health (AMH) Services

Bromley
Limited views were expressed about AMH services in Bromley. These came via the Co-occurring Mental Health Alcohol and Drug (CoMHAD) lead, Drug & Alcohol service, and SW practitioners. Relationships between AMH and D&A services continue to develop due to the creation of the relatively senior CoMHAD liaison post (which also has a service development and training remit as well as working with clients/patients with co-occurring MH and D&A issues). Relationships with AMH were previously described as "dire" but now improvements are being made.

Attempts were made to link with other AMH practitioners via LIFT practitioners and key stakeholders in the area, but it has not been possible to recruit any other AMH representatives in Phase 1 in Bromley.

It is reported there is effective multiagency working in Bromley generally in relation to families. However, within South London and Maudsley mental health services there appears to be a reluctance to "hold" safeguarding and SW services in the area do "push back" due to a view that it is everybody's responsibility.

Glasgow
A key stakeholder at consultant and service design level identified that there are significant limitations across the tiers of AMH services to considering adults' needs as parents, and in relation to understanding and supporting co-occurring drug and alcohol issues.

They reported that there remains a significant gap in AMH service provision for parents who may have a trauma history, multiple dependents, and who are facing material adversities in Glasgow. Existing AMH tiers of service do not currently accommodate pathways into or out of services for this population. A gap has been identified and funding was agreed but due to budgeting cuts it was then withdrawn by the Scottish Government.

Child and Adolescent Mental Health Services (CAMHS)

A key stakeholder practitioner recognised that children rather than families remain the focus in CAMHS services. Wider family need for support is not always recognised but there are robust supports in place for practitioners who have safeguarding concerns. Demographic and chronological information is not always available to practitioners and there are not currently shared systems which may highlight any growing family concerns.

Infant Mental Health

Glasgow
In terms of IPS access: Social Care Direct, Wee Minds Matter, GP, HV Teams, Early Years educators, third sector family supports (including for families from a range of cultures and ethnicities), and Family Nurse Practitioners, are all relevant services that may wish to refer to IPS.

Bromley
SW, GP, HV Teams, Early Years educators, Bromley Children's Centre, third sector family supports (including for families from a range of cultures and ethnicities) and the Early Intervention and Family Support Team are all relevant services that may wish to refer to IPS.

RQ3: What are struggling families' experiences of, and barriers/access to, mental health services?

Themes: "*Barriers", "facilitators", "system change" and "developing relationships"*

Headline: All stakeholders identified barriers which highlight difficulties encountered by vulnerable families accessing services. Practitioners and PCs considered a wide range of barriers that exist. Findings would suggest barriers could be viewed as a 'wicked problem' as they relate to societal, systemic, individual service limitations, service resourcing issues, practitioner limitations and parents' personal difficulties and material circumstances.

Facilitators were also identified by all stakeholders, and these also included systemic, service, practitioner, and parent/infant and family support. Examples of existing practice and suggestions for future national, local, and service developments were also discussed and described by all stakeholders. Please see Appendix 1

Barriers

Glasgow

HVs, Glasgow Infant and Family Team (GIFT) practitioners, D&A, SW and Adult Mental Health (AMH) stakeholders perceived that families facing multiple adversities, who are living in areas of multiple deprivation, are affected by limited access to services; and service responses do not always reflect families' levels of need.

HVs reported that, particularly in areas of multiple deprivation, service providers can become desensitised to working in these settings. This can skew their perception of families' actual level of need. By the time families are categorised as vulnerable they are often extremely vulnerable with heightened levels of need.

HVs perceived specific vulnerabilities for asylum seeking families which have been highlighted in RQ2. They also acknowledged, through direct contact with asylum seeking families, that there are different pathways into services (due to Home Office jurisdiction). Due to their home visiting role HVs understand first-hand, that asylum seeking families are often housed in temporary, sub-standard accommodation, on the poverty line, and have recent experiences of trauma. All of these factors increase their vulnerabilities.

HVs reported perceptions that LA SW services and practitioners are so stretched they are often not in contact with vulnerable families even when Notification of Concerns (NOC) are raised by HV. It was reported that families can wait weeks, or the NOC may not be prioritised by SW due to HV perceptions around SW workloads. HVs viewed this as a crucial time when families' problems can escalate further.

This finding highlights a difference in understanding at universal services level regarding who remains the 'Lead Practitioner' at this point. In Getting it Right for Every Child the Lead Professional for the 0-5 age group who holds the responsibility for building relationships with families would be HVs. Alternative routes to support for families should be considered if SW as a tertiary service is unable to respond.

In Glasgow the AMH key stakeholder reported that families from different cultural and ethnic backgrounds do not refer into AMH services due to extended families leading in offering practical support for parents facing difficulties. Mental ill health can be left unaddressed due to stigma. Problems can then escalate significantly for parents experiencing mental ill health who have young children.

GIFT, HVs and CAMHs practitioners acknowledged that a lack of shared data and systems regarding family/child chronologies can also create obstructions to service access, and gaps in practitioner understanding of how long families may have been vulnerable for. This can lead to service response delays and families' potential problems escalating further.

Bromley

Bromley is generally a well-resourced area but HVs do see material adversity, social isolation, and poor housing for families that are on their caseloads. HVs are increasingly experiencing lower parental engagement with HV services since COVID lockdowns, and staffing levels are not at full capacity for their service. This has led to gaps in face-to-face contact with families and HVs have utilised a hybrid approach to maintain contact by phone, home visits and visits at family centres. These factors can make it harder for HVs to stay in meaningful contact with families experiencing difficulties.

Barriers identified in both areas

GIFT and London Infant and Family Team (LIFT) are Teams that are Infant Mental Health services that are directly accessed via court systems and Children and Families SW teams once Child Protection proceedings have been initiated for children under age 5. GIFT and LIFT practitioners reported that there was a general lack of knowledge societally, and within universal services, and individual specialist services around effective screening for infant mental health and wellbeing, understanding infant mental health crisis, and what cues and

miscues look like in infants. These practitioners also identified a reluctance from universal practitioners to consider that babies may not be happy.

GIFT and LIFT practitioners acknowledged that family journeys into service are often long and involve multiple points of access, or that families have remained 'under the radar' of services due to gaps in support for families with infants aged between 0-5.

PCs and practitioner stakeholders perceived that when families do encounter services common factors include multiple vulnerabilities and adversities. These include material, financial and psychological components. The impacts of trauma, Adverse Childhood Experiences (ACEs), Domestic Violence (and multi-generational trauma), poverty (lack of money, poor housing and being situated in areas of multiple deprivation), and social isolation (lack of support, no partner, and asylum-seeking families), experience of judgement from practitioners and fear of service interventions (particularly LA SW) are factors which affect whether people engage with services or not. Individual adult and child services are not usually set up to address the range of issues that may be present for families that need support.

D&A staff and HV stakeholders reported service limitations including changes to the level of support offered. This is due to restrictions on service remits because of limited resourcing. There is less scope to engage with practical support for families such as completing forms and liaising with housing support, etc. than there used to be in services.

A number of practitioners reported perceptions that LA SW service thresholds impact negatively on families' access to earlier practical support which they felt could avert family problems escalating to crisis level. Interestingly, a small number of these stakeholders also requested more training on SW processes. This finding could indicate a disconnect between practitioners' understanding of SW processes and procedures, and alternative referral pathways.

SW practitioners in both areas discussed the importance of empowering other health colleagues to hold safeguarding cases rather than presume it is SW responsibility.

PC and practitioner stakeholders all reported and acknowledged the personal barriers parents face in their engagement with services. These barriers include the specific fear of SW involvement, the stigma attached to receiving input from SW and other services, and how fear impacts on parental understanding of what will be involved (i.e., what is being communicated is not always how it is interpreted by parents).

Practical and financial barriers were also reported. These included having the means (in person and digitally) to engage and attend meetings, therapy, treatment, etc. Barriers included a lack of childcare and material and time resources required to attend multiple meetings with multiple practitioners over short timescales. One D&A practitioner stakeholder perceived that SW staff generally lacked understanding about realistic recovery timescales for parents that had past trauma histories and the therapeutic work that is involved to effectively support these parents within D&A services.

PC and practitioners perceived that fear of losing children and entering into child protection proceedings can lead to parents masking their own escalating need for support from practitioners as a way to keep their families together.

Appropriateness of assessments

PCs considered that assessments for NDCs and/or trauma in children can be confusing and that NDCs can be discounted in favour of a trauma diagnosis. During one GIFT Team focus group, there was a consensus in which members recognised that this can be a contentious issue for parents and practitioners.

There is a perception held by a small number of practitioners working within universal and IFT teams that LA SW assessments are affected by budgets, service limitations and thresholds, particularly in Greater London, but also in Glasgow.

How individual assessments are carried out and interpreted across HV services can vary. HVs recognised that this can impact on whether a family remains on the “universal” or are moved to the “high priority” pathway. There is room for error in terms of identification of vulnerabilities and need.

LIFT practitioners recognise that paediatricians and HVs have central roles in assessing children and that early, thorough assessments are crucial to building accurate understanding of parent and child needs in relation to NDCs, D&A misuse and appropriate support. GIFT and LIFT practitioners recognise the practical focus of infant assessments carried out in other services, but that knowledge of the impact of trauma, and infant mental health and wellbeing is often missing.

Assessments carried out by other services (including AMH & SW) resulted in inappropriate D&A service referrals and re-referrals. D&A practitioners perceived this issue to centre around a lack of practitioner knowledge around differences between substance use and misuse. All D&A practitioners felt this led to stigmatising some clients unnecessarily which then negatively impacted on true client empowerment. PC, D&A and AMH practitioners reported that ‘bounce’ between AMH and D&A services for parents that self-medicate to deal with past and present adversity remains problematic for parents requiring input from both services.

In Bromley there are lower than expected referrals coming in from HV into the hub and safeguarding support. However, post Lockdown, HV reported that numerous families in the area had chosen not to opt in to accept support at universal level (GPs were notified when this occurred). Also, capacity issues were highlighted by HV in that area and working practices have been modified in order to adapt effectively. These factors may partially explain this perception.

In terms of the changing landscape and identification of parental and child mental health needs, one senior practitioner in the area noted that families experiencing high deprivation might be seen as neglectful families, but these families should actually be regarded as struggling families because they are dealing with real issues and are not necessarily poor parents.

This was even more challenging during COVID and, since the pandemic, the Bromley team have seen many more children with the “mental health” label when their problem may be neurodevelopmental. Some of these children have a complex range of problems and their parents are feeling unable to cope.

Additional Barriers

Practitioners identified limitations in terms of services not being set up to recognise and engage with the needs of parents in CAMHs, and children’s needs in AMH. Understanding the intersectional needs of parents, and appropriate service responses to families from minoritised ethnic groups were also considered to be barriers to engagement.

Viewing and understanding adults as parents in AMH services can also be overlooked. This is a service limitation in terms of understanding what issues of importance might be around for parents in AMH services and what might be compounding episodes of mental ill health.

HVs reported that a lack of practitioner understanding regarding how different cultures operate can exacerbate poor working relationships between service providers and families. Also, in London the cultural and ethnic mix of LIFT staff teams does not always reflect the population. This was reported to be a consideration for both personal and service

engagement and in the identification of potential barriers to accessing services for disenfranchised families.

> Well, you could a dive into our figures, but I mean one thing that comes up repeatedly is the ethnicity of our team doesn't reflect the ethnicity of the people that we're working with on the whole, so there's a mixture, but obviously it depends where you're looking at.
>
> LIFT team practitioner

D&A practitioners considered the digital divide (using Teams, data, etc.) for families on limited budgets who have limited IT skills. Although online meetings are also viewed positively in terms of saving parents time/being less intimidating than sitting in a room full of professionals, etc. it is important to recognise that personal barriers to accessing services and support online can also include parent/child safety if their current situation involves risk of DV; and if families are experiencing financial adversity there may be a lack of internet access/data. All services need to factor these possibilities in, otherwise this could become a contentious issue in relation to understanding parent/family service engagement and compliance.

LIFT, GIFT and HVs perceived that 3–4-year-olds can be lost to services if they are not accessing early years education (depending on family circumstances). Again, this problem is recognised in both areas.

Personal barriers for parents around shame, fear and stigma need to be better understood and responded to across services working with vulnerable families. These feelings can be exacerbated by practitioners within services, and this can prevent appropriate help-seeking from parents.

Limitations with the legal systems in both areas were highlighted by LIFT and GIFT practitioners, HVs (in Glasgow) and D&A practitioners in both areas. Concerns were articulated about the Family Drug Courts in England, the Children's Hearing Systems in Scotland, Child Protection hearings, and criminal justice processes for adult drug users referred to D&A services.

Resourcing support for families involved in court proceedings in Bromley can be problematic for numerous reasons. In terms of resourcing issues and fragmented services in relation to adults and children. A senior SW explained that during "heavy end" court proceedings, when therapeutic services are required for parents, these are often not readily available. Children's social work services have a dilemma because although the service is for an adult, and they are a children's service, the parent getting/not getting this service would directly affect the child. From the perspective of both the courts and the parents, there is a perception that, without this service, a willing parent is not being supported to care for their child. Sometimes children's services have felt compelled to provide the funding, or to negotiate with other organisations to provide the help.

HVs and D&A workers in Bromley also reported lags between electronic and wider systems and information sharing between areas and services when people move in and out of area. This can be problematic in terms of continuity of care. Also, when families' cases are shared across multi-agencies *who* the professional lead is when taking action for families was also reported to be problematic by HVs.

Longer term issues for families

One senior SW recognised there were particular issues for parents with a history of trauma who experience repeated cycles of child protection proceedings. These vulnerabilities can result in them becoming "severely disadvantaged" in the longer term. Also, separating siblings in care can have a lasting negative impact on families. While these are not

necessarily explicit barriers to access, they can lead to longer term issues and consequences for parents and children where higher tiered interventions have been initiated.

IFT and SW practitioners recognise that there will always be a small percentage of families that are unknown to services before crises happen.

Facilitators

D&A and AMH Services

Bromley

The Co-MHAD Lead post, as a conduit between AMH and D&A services in this area, has been found to be important in creating better partnership working. The Co-MHAD Lead holds a training and educational role with AMH staff and informs the Trust about nature of developing roles. The secondment is currently under review.

Re access to D&A support:

> "…there's a clause within the Oxleas [NHS Trust] code of conduct … which specifically stipulates that somebody's mental, somebody's substance use does not get in the way of them accessing for an assessment… I think it's Section 5.1, that significantly says that it does not get in the way of them accessing for an assessment. So, you can't be turned away at the first hurdle, which I think is SO powerful."
>
> D&A Practitioner

D&A services in Bromley do not exclude people from service if an AMH problem is co-occurring. AMH in the area is now catching up. D&A services also offer a range of person-centred recovery and community resources for parents. The service can work with children aged 8+ but the post was vacant at the time the interviews took place.

AMH & D&A have lived experience practitioners, volunteers, peer mentors, etc. Developments are ongoing to-locate a range of services within community hubs and substance services & AMH services "mainlining" in local GP surgeries.

Health Visiting Services

HVs report close links with Bromley Children's Project. HV refer to "Vulnerable families" links in this service where a "Light Touch" intervention, is triggered by HVs and followed up by Bromley Children's Project. These targeted pathways are triggered when necessary to support vulnerable mothers. HVs provide information to new parents about other resources. Midwife, HV & other disciplines also operate from the children's centre.

Other services

In Bromley there is a vulnerable adults midwifery team, with a skilled, experienced, and respected local safeguarding midwife, there is the well-resourced Bromley Children's Project, and there are lived experience practitioners in safeguarding and D&A team. There is access to an interpreting service across services. The Phoenix Centre is a key resource for assessment of NDCs in children and there are paediatricians, etc. on site.

Additionally, in this area local children and family centres work in a non-statutory way with local families and offer a range of supports including tiers of parenting programmes for a range of ages and specific needs and the service also includes drop-in facilities. Parenting practitioners work alongside families with a SW or who are stepped down to access other support. The service also supports families with higher tiered Child in Need plans where there is direct SW involvement.

Strengths based SW practice – both areas

Glasgow SW leads discussed how exclusively risk-focused practice negatively impacts on direct working relationships with families, particularly parents. Some practitioners focus on family deficits or risks, without a focus on their strengths and assets to balance perspectives. This then becomes problematic in terms of building relationships with families and in relation to providing appropriate levels of support from services. SW leads are working hard to shift the focus back to strength-based approaches to working with families where understanding, curiosity, engagement, and empowerment should be the obvious focus, and risk should be sensitively considered within each family context. Also, stepped withdrawal of services where the door remains open was considered to be more empowering than complete withdrawal for families that experience social work involvement. Recognising there is likely to be fluctuation in families' progress was also considered to be a more realistic and person-centred approach to service delivery.

LA SW services receive a range of referrals, some "early years" referrals are reported to be wholly appropriate for the range of assessments carried out, while others are referred on to universal or third sector services. Parents and children are assessed if there is an AMH SW referral. SWs reported that if early screening of the family and child's situation takes place (through dialogue with Primary Care health care and early years services) this can avoid additional stress and anxiety for parents involved with AMH SW as children's circumstances can then be better understood.

The Bromley SW lead recognised the importance of working to build relationships with families to support and enable parents to identify problems and any help required rather than this being service led. Also, they acknowledged that providing a better SW systems approach to regular changes of SW staff and moves between teams would limit families having to repeat their stories multiple times which can negatively affect working relationships with families.

Multiagency and multidisciplinary forums for thinking about and planning support for families was also highlighted as a facilitative.

In some LA areas in England (not Bromley) there are multiagency safeguarding teams where each practitioner is funded by each service. This approach to resourcing supports a multidisciplinary range of professionals to work directly with families in a unified way.

Glasgow

Infant Mental Health Team – Wee Minds Matter

GIFT and LIFT Team practitioners discussed how helpful the implementation of the new Glasgow Infant Mental Health Team is for infants in need in terms of bridging a service gap (aged 0-3).

> "Glasgow Infant Mental Health Team, so that is a new resource, it's not a huge resource, but it is a new resource particularly for families with very young children and there's also enhanced perinatal services and, um, maternity and neonatology

> services as well, so they would all be options and pathways that should be available to families…"
>
> GIFT Team Practitioner

The Autism Resource Centre

The Autism Resource Centre in Glasgow is an ongoing development which is currently under review. Further information on this resource is not available at this time.

AMH in Glasgow

There are short waiting lists into Primary Care Mental Health Team services with the ability to self-refer, and web access materials for AMH, CMHT responses mean adults are usually seen within 5 days, and people referred with immediate risk are seen on the same day.

Lanarkshire universal observational indicator set

All health, social care and universal professionals are working towards developing a shared language around IMH and taking a shared responsibility to communicating about red flags, observations, etc. in the Lanarkshire area. IMH needs have been brought to the awareness of all practitioners across services in this geographic area.

Other facilitators

Self-referrals

The ability to self-refer into D&A services was highlighted as a positive change for people (particularly female parents) being able to self-identify needs compared with past referral systems. The key stakeholder in AMH also highlighted self-referral into AMH services as a positive change for people being able to self-identify compared to past service access processes.

Access to NDC support

CAMHs do not usually see children under age 5 however they are receiving more HV services referrals since the pandemic due to waiting list awareness on the part of the HV; this is a way of opening pathways for early access to NDC support.

Lived experience practitioners in working teams

All PCs and practitioners interviewed could see the benefits and value of working alongside people with lived experience in supporting families. Employing lived-experience workers is common in D&A and some AMH services. However, this practice is not yet commonplace other health and social care services that work with families. Phase 1 has highlighted what lived experience practitioners can bring to service developments by providing a professional and empathic approach to working directly with families. Lived experience practitioners were reported to be valued colleagues that enrich and strengthen team understanding of ongoing issues for people using services, and practices that positively and negatively affect families in contact with services.

Visibility and accessibility of services

> "I think…services being visible, and part of communities is really important and to be able to see services as somewhere that you belong and as something helpful it's really an important…baseline, isn't it?"
>
> "…thinking about IPS the last couple of days where we were talking about really trying to help families with the here and now, the immediacy of their needs, because a cumulative impact of stress on their family, on a child, is where the damage is done really."

GIFT practitioner

Microsoft Teams, or other remote forms of access, can be less intimidating for parents than physically being in a room with a range of practitioners from a range of disciplines.

> "I wouldn't think, 6 professionals sitting there staring at 1 woman, trying to keep a child quiet because she had no childcare is particularly good for anxieties or discussing a plan in a rational way…"
>
> D&A practitioner

Developing relationship with parents is crucially important:

> "I think people can be very effective assessors, very effective nurses, …but I think sometimes we do miss the softer qualities that come with making people a little more comfortable when accessing services in their environments, you know, I know we have a job to do and we have X amount of questions to get through, but I think we could do a little bit of work, more than a little bit of work with our services around… injecting a bit more compassion in how we approach people."
>
> Co-MHAD lead

Understanding the impact of poverty

One SW Lead considered the importance of professionals' ability to understand the impact of poverty on people's lives. They recognised that this is no longer families SW would "traditionally" be working with and there needs to be more practitioners in universal services being able to identify need and offer earlier support/signposting.

They recognised that there is often a complex set of circumstances for families where there can be several different professional interpretations of what has been observed. This can lead to a "spectrum" of concern around risk and whether issues are "attributable" to parents or whether it relates to societal issues.

RQ4: What is the profile of services-as-usual (SAU) (including infant/adult mental health; social care statutory processes) at each site and can care pathways be improved?

Qualitative findings from Phase 1 would suggest that profiles for service-as-usual at each site differ.

Lists and maps of care pathways for services have been drawn up from qualitative findings for each service interviewed (See Appendix 2). These are not exhaustive as stakeholders interviewed did not provide a complete view of the service landscape across each area.

The pathways can be improved but issues relating to where improvements are necessary often relate to the wicked nature of the problem. Viewing it as a wicked problem enables researchers to consider the societal, systemic, service and personal barriers into and out of services when thinking about parent and infant pathways. The 'why and where' doors close, and the 'why and where' parents might disengage with services. This also includes careful consideration of intersectional needs and the needs of minoritised groups in both areas.

Please see barriers identified in RQ3.

Positive and negative 'relationships' and 'resources' are key qualitative themes that inform the above analysis. Relationships between systems and services, and relationships between services, practitioners, and families (including parents and children), all impact on pathways and individuals service access.

Final reflections

As part of its development this document has been circulated around certain key stakeholders including PC, Senior Social Work, and CAMH leads. Through subsequent discussion it has been noted that the findings have identified perceptions by practitioners in GIFT and LIFT Teams, HVs, AMH and D&A services of high SW service thresholds and specifically gaps relating to this for families before/approaching crisis. AMH and D&A practitioners also identified training needs in terms of their own service staff understanding of SW processes and intervention levels. We have been struck that this raises questions about a lack of knowledge about current SW practices across services (particularly in Glasgow). For example, senior social workers in Glasgow reflected that a referral to SW from health is a "notification of concern" and because this indicates a child protection concern these are never ignored, yet having SW intervention too early can sometimes do more harm than good. This raised the question of who could fill these gaps in supporting families at an earlier stage, and who intervenes and refers on when? These are questions that we anticipate will be given further consideration in Phase 2.

In Glasgow, senior leaders voiced the opinions that the policy aspirations of Getting it Right for Every Child (GIRFEC) are still being assimilated into frontline practice in Scotland. This means that there is a training and confidence gap for some frontline practitioners in being able to support a family through difficulties or into supports, without a 'referring on' culture. The cultural transformation challenged by The Promise necessitates that all services work towards a shared ethos of effective helping at the earliest stage by those who have the relationship with the family. Cultural change is a lengthy process and necessitates supporting partners in other services to recognise the potential of their early support of families.

These findings highlight services resourcing the 'right' support for parents and children is still reported to be problematic. Adult services tend to resource adult support and children's services resource children's support. In this respect resourcing can be problematic when parent and child needs interlink. This issue would benefit from further exploration to help identify potential ways to streamline access to symbiotic resourcing and support for parents, children, and services. To some degree, this problem could be offset by the Team Around the Child approach (included in GIFREC) in Scotland - where the right practitioners work flexibly together, to provide support but this was not part of the findings in Phase 1. Our findings suggest that not all services and practitioners that have been considered in the content of these interviews are in a position to respond to parent and child support needs flexibly.

Finally, as part of research mapping activities carried out during Phase 1 resources for each geographic area has been developed in spreadsheet and weblink bookmarks formats identifying a range of family, and parent and child related supports for each area. These living documents can be circulated and updated as required as part of dissemination activities and IPS intervention development. Next steps in Phase 2 will be to identify which services (as alternatives to social work) would provide appropriate support to families being met further upstream.

Limitations

Qualitative data have been gathered from a modest sample of participants and the perceptions presented here are therefore not necessarily generalisable to other geographical locations. More needs to be understood about pathways out of services, potential 'stuckness' in services and 'bounce' between services from the perspective of parents. This has mainly (but barely) been considered from a practitioners' perspectives so far during this phase. Anecdotal comments from PC have highlighted that local, third sector counselling and practical support helped them significantly on their journey to moving out of services. Also, D&A practitioners recognised the importance of stepped, third sector recovery support

for adults moving forward from substance misuse issues. In addition, the mapping of pathways is likely to benefit from more work during Phase 2 as it is based solely on the qualitative interviews from Phase 1. The major limitation is that, due to ethical restrictions, we have only just been able to begin interviewing Parent Collaborators so their voices are largely missing. This work will not be complete until Parent Collaborator voices are able to be fully heard.

Key recommendations to be taken forward in Phase 2

Future similar projects would benefit from the PC Coordinator being employed full time in order to support greater PC involvement in coproduction.

A better balance of PCs and practitioners is needed in decision-making meetings to ensure PC voices are not drowned out.

Understanding which services (as alternatives to social work) families need to help them when problems begin to escalate would help inform processes and practices in relation to appropriate referral routes which suit families better. This could be explored as part of the work on PROMs and PREMS component of Phase 2.

Ethical processes should regard PCs as professionals so that they can be interviewed equitably along with other professionals and therefore have equal voices.

A dedicated administrative lead taking minutes, ensuring meetings were recorded and circulating links and information could have addressed this unanticipated issue.

There are services such as the Phoenix Centre in Bromley which could potentially be a previously unidentified resource where families experiencing difficulties could be referred into IPS. The service maps developed as part of the Phase 1 process evaluation should become an integral part of IPS to facilitate good links and partnerships between services.

References

1. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf.
2. Waldmann T, et al. 2021, 5(1): 1-11. https://capmh.biomedcentral.com/track/pdf/10.1186/s13034-021-00360-y.pdf
3. Holmes L, McDermid S. Understanding costs and outcomes in child welfare services: Jessica Kingsley Publishers; 2012.
4. Ward H et al. Costs and Consequences of Placing Children in Care. Ward H, editor. London: Jessica Kingsley Publishers; 2008.
5. Campbell C. Commission on the Future Delivery of Public Services Scotland: APS Group - DPPAS11647 (06/11); 2011 https://www.gov.scot/binaries/content/documents/govscot/publications/independent-report/2011/06/commission-future-delivery-public-services/documents/0118638-pdf/0118638-pdf/govscot%3Adocument/0118638.pdf?forceDownload=true.
6. Self-Brown S, et al. 2017;32(8):751-66.
7. Review IC. The Promise Glasgow2021 [Available from: https://www.carereview.scot/wp-content/uploads/2020/03/The-Promise_v7.pdf.
8. Government H. The Early Years Healthy Development Review Report. 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973085/Early_Years_Report.pdf

9. Government U. Independent review of children's social care England2021 [Available from: https://www.gov.uk/government/groups/independent-review-of-childrens-social-care#about-the-review.
10. NSPCC. Infant and Family Teams. 2021 [Available from: https://learning.nspcc.org.uk/services-children-families/infant-and-family-teams.
11. Turner-Halliday F et al. Child Abuse & Neglect. 2017, 72: 184-95. http://dx.doi.org/10.1016/j.chiabu.2017.07.012
12. Zeanah CH, et al. Journal of the American Academy of Child & Adolescent Psychiatry. 2001, 40(2): 214-21. https://doi.org/10.1097/00004583-200102000-00016
13. Robinson LR et al., editors. Child & Youth Care Forum; 2012: Springer.
14. Harvard U. https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/InBrief-The-Science-of-Resilience.pdf.
15. Best practice guidance: Support for and work with famillies prior to court proceedings. 2021.
16. Independent rocssc. The Case for Change. 2021.
17. Crum KI, Moreland AD. Journal of Child and Family Studies. 2017, 26(11): 3067-78. 6 https://doi.org/10.1007/s10826-021-01904-8
18. Theule J et al. Journal of Emotional and Behavioral Disorders. 2013;21(1):3-17. https://journals.sagepub.com/doi/pdf/10.1177/1063426610387433
19. Hsiao Y-J. 2018, 53(4): 201-5. https://journals.sagepub.com/doi/pdf/10.1177/1053451217712956
20. Skinner GC et al. Children and Youth Services Review. 2021, 120: 105678. https://doi.org/10.1016/j.childyouth.2020.105678
21. Davies C, Ward H. Safeguarding Children Across Services. Davies C, Ward H, editors. Jessica Kingsley, London and Philadelphia 2012.
22. Broadhurst K, Mason C. 2017;31(1):41-59. https://academic.oup.com/lawfam/article/31/1/41/3065577?login=true
23. Reiss F et al. PloS one. 2019;14(3):e0213700. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0213700
24. Bywaters P, Child WIPT. The Child Welfare Inequalities Project: Final Report. 2020. https://pure.hud.ac.uk/ws/files/21398145/CWIP_Final_Report.pdf
25. Cross S et al. The British Journal of Social Work. 2021. https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcab130/6350060?login=true
26. Morriss L. Haunted futures: The Sociological Review. 2018, 66(4): 816-31. https://core.ac.uk/download/pdf/185511208.pdf
27. Hefti S et al. Journal of marital and family therapy. 2020, 46(1): 95-109. https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmft.12367
28. Dinkler L et al. Journal of Child Psychology and Psychiatry. 2017, 58(6): 691. https://acamh.onlinelibrary.wiley.com/doi/epdf/10.1111/jcpp.12682
29. Bilson A, Bywaters P. Born into care: Children and Youth Services Review. 2020, 116: 105164. https://www.sciencedirect.com/science/article/pii/S0190740920301894
30. Barlow J et al. Drug and Alcohol Dependence. 2019, 194: 184-94. https://www.sciencedirect.com/science/article/pii/S0376871618307713
31. Juffer F et al. Video-fedback intervention to promote positive parenting and sensitive discipline. Handbook of attachment-based interventions New York: Guilford. 2018.
32. Bachmann CJ et al. Journal of child psychology and psychiatry. 2021. https://acamh.onlinelibrary.wiley.com/doi/epdf/10.1111/jcpp.13461
33. Soper J et al. Costs and consequences of placing children in care: Jessica Kingsley Publishers; 2008.
34. Scottish G. Children's Social Work Statistics Scotland, 2018-2019 2020 [Available from: https://www.gov.scot/publications/childrens-social-work-statistics-scotland-2018-2019/pages/3/.

35. Euser S et al. BMC public health. 2015, 15(1): 1-14. https://doi.org/10.1186/s12889-015-2387-9

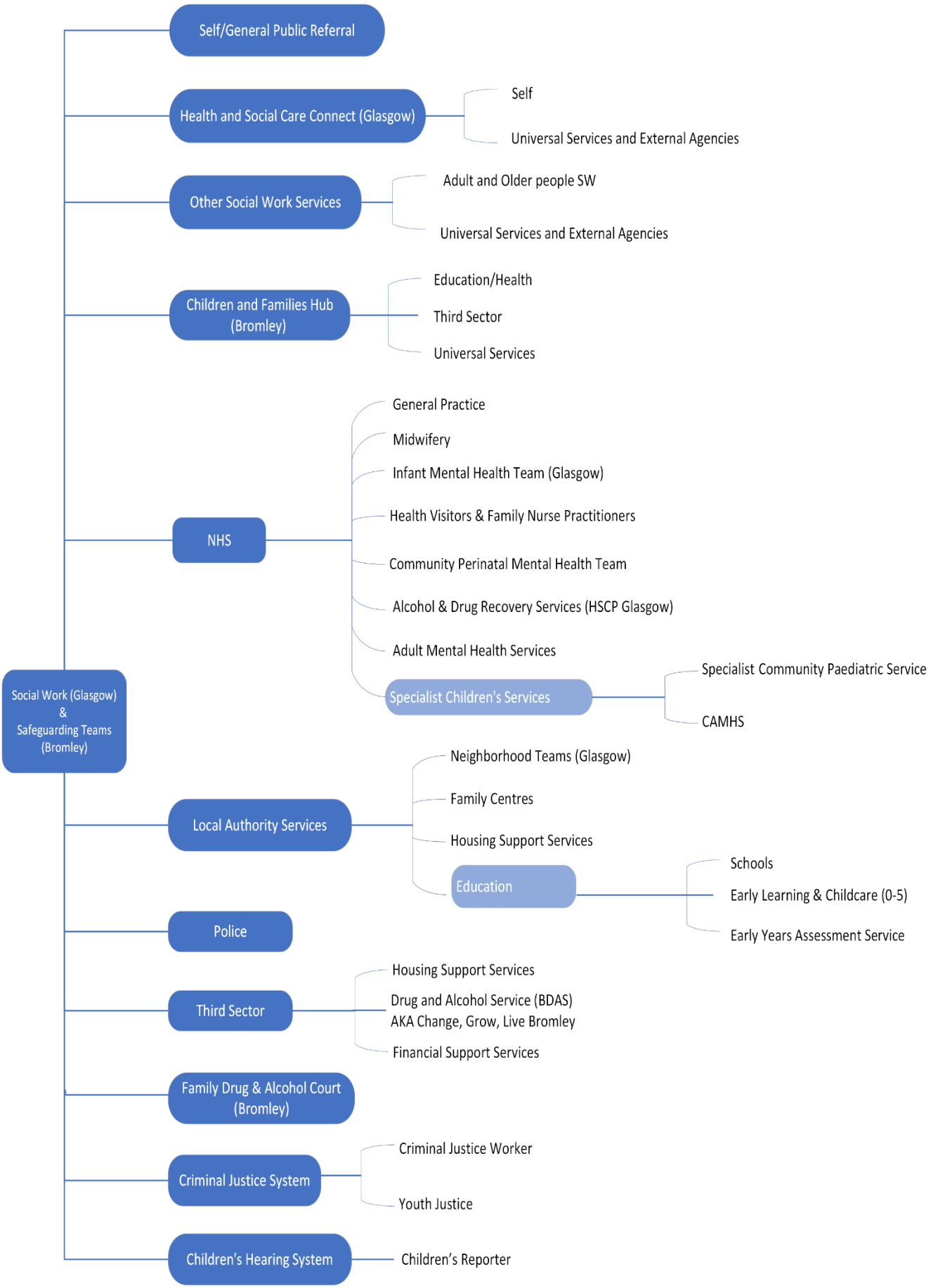
Appendix 1

Key attributes or systems that promote relationship building and practical support across services working with families

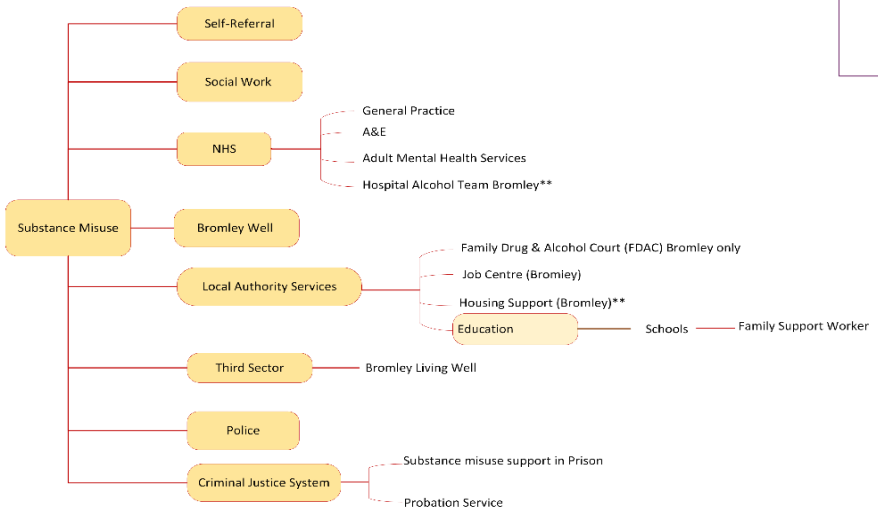
- Service values promote and reflect genuine trust between families and workers.
- Empathic and person-centred approach to parents
- Poverty aware approach
- Strengths based approach to working with parents and families.
- Flexibility with service appointments, responses, and support for parents with young children
- Microsoft Teams can facilitate better attendance and involvement from a range of MDT practitioners
- Transparent communication between services and sectors
- Good multi-agency/cross sector relationships and knowledge of roles and functions
- SWs working within multi-disciplinary teams develop a better understanding around NHS services and systems.
- SWs learning about formulation has been a real positive when working within well-resourced GIFT and LIFT services.
- Family Liaison staff working in collaboration with parents.
- D&A and lived experience practitioners empowering people to move forward in their journeys to access more appropriate support in different forms.
- LA SW developing systems to support parents where NDC are suspected in children (pre diagnosis).
- SW working holistically with families considering personal, psychological and material needs and responding accordingly.
- SW developing mechanisms to incorporate lived-experience perspectives to better understand parental experiences and needs.
- Specific services providing a “holding” relationship when other services cannot be accessed.
- AMH staff looking out for MH/wellbeing of children.
- HV senior managers seeking additional funding to increase staff to work adequately with more vulnerable caseloads.
- HV team of MDT early years support link well with Third sector.
- HV promoting community integration to combat social isolation (for asylum seeking families and more widely).
- Assertive outreach and dedicated service for parents with SW involvement in D&A services in Glasgow.
- There are linked SW systems for referring adult parent and child at same time where there are AMH concerns.
- MDT supervision benefits all staff and promotes practitioner reflection, thorough understanding of each family’s circumstances, and team cohesion.
- Open and honest dialogue with parents that is not punitive.
- Better linkage between AMH and D&A services for adults where gaps are closed and bounce between services is stopped.
- Social work colleagues need to have manageable caseloads if they are to respond to struggling families’ needs rather than only when risks have emerged

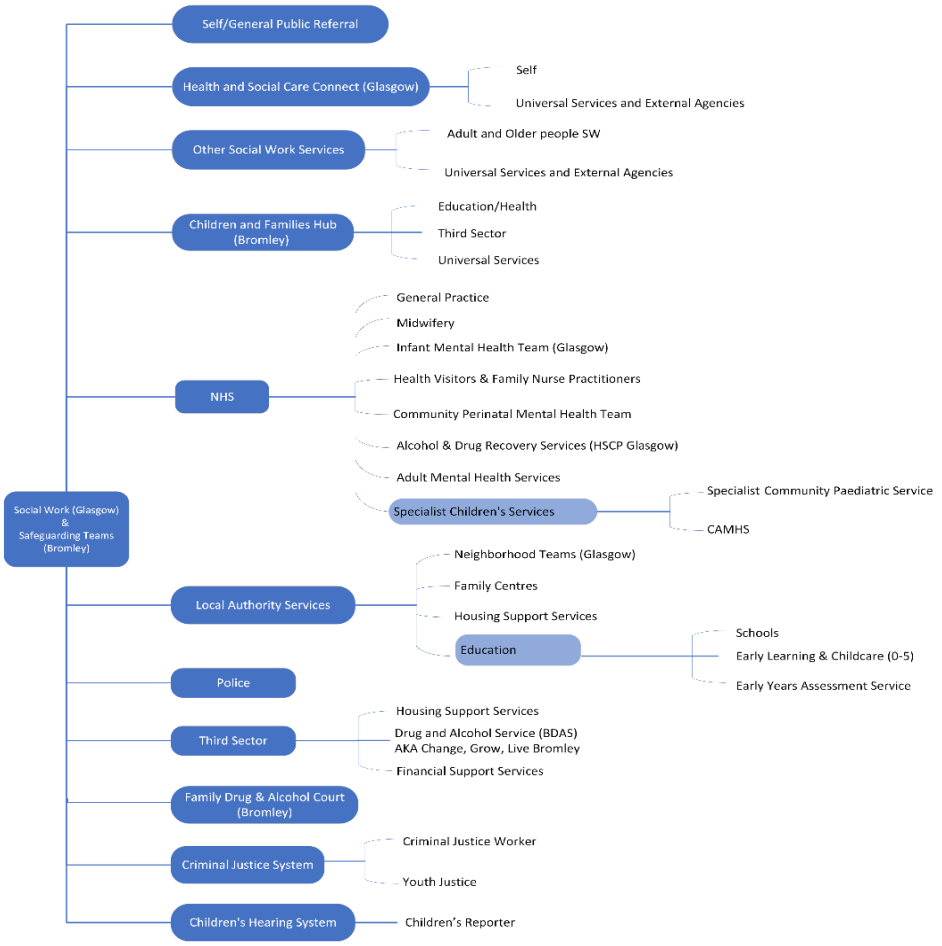
Helpful national, system and service developments identified by the range of practitioners interviewed:

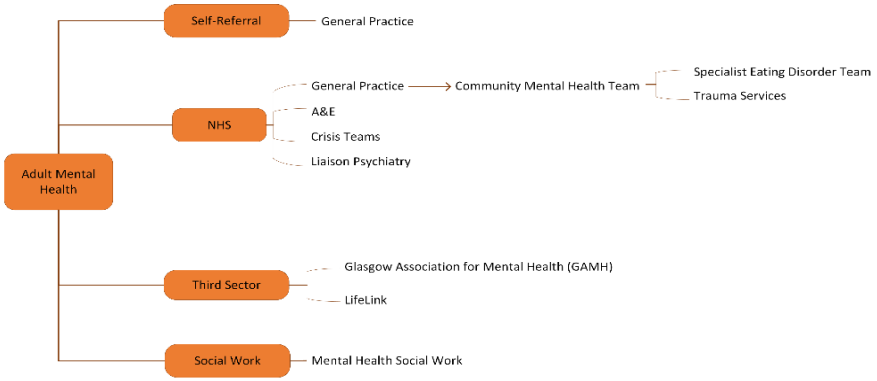
- National, local and service policy developments
- An overhaul of the legal system for vulnerable families
- An overhaul of Criminal Justice system for drug users (including those who are parents)
- Infant Mental Health Public Health campaigns
- A consultative role for GIFT & LIFT Teams educating other practitioners around IMH
- Training across universal services in understanding IMH and identifying need in relation to IMH crisis.
- Training for some universal and Tier 2 services on Trauma, Asylum and SW processes.
- Better training for SW on Trauma and Drug and Alcohol use and misuse, and appropriate D&A service referrals.
- There needs to be a clearer understanding of SW and thresholds of need across universal and specialist services. Wider services need to develop abilities and practices to hold perceived risk more effectively and refer on elsewhere when appropriate.
- Reflexive training for a range of practitioners in universal and higher tiered services when identifying risk appropriately in relation to what is being defined as neglectful parenting and what is actually as a result of external factors, for example, the cost-of-living crisis.

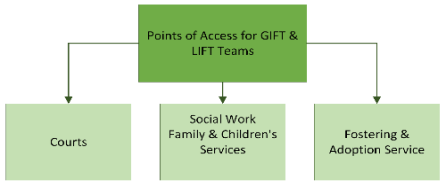

Social Work (Glasgow) & Safeguarding Teams (Bromley)
Self/General Public Referral
Health and Social Care Connect (Glasgow)
Self
Universal Services and External Agencies
Other Social Work Services
Adult and Older people SW
Universal Services and External Agencies
Children and Families Hub (Bromley)
Education/Health
Third Sector
Universal Services
NHS
General Practice
Midwifery
Infant Mental Health Team (Glasgow)
Health Visitors & Family Nurse Practitioners
Community Perinatal Mental Health Team
Alcohol & Drug Recovery Services (HSCP Glasgow)
Adult Mental Health Services
Specialist Children's Services
Specialist Community Paediatric Service
CAMHS
Local Authority Services
Neighborhood Teams (Glasgow)
Family Centres
Housing Support Services
Education
Schools
Early Learning & Childcare (0-5)
Early Years Assessment Service
Police
Third Sector
Housing Support Services
Drug and Alcohol Service (BDAS)
AKA Change, Grow, Live Bromley
Financial Support Services
Family Drug & Alcohol Court (Bromley)
Criminal Justice System
Criminal Justice Worker
Youth Justice
Children's Hearing System
Children's Reporter


Social Work Child & Family Disability Services
NDC
NHS
Health Visitor
Specialist Children's Services
CAMHS
Specialist Community Paediatric Service
Speech and Language Therapy
Local Authority Services
Autism Resource Centre (ARC) Glasgow
Phoenix Children's Resource Centre (Bromley)


Self-Referral
Social Work
NHS
General Practice
A&E
Adult Mental Health Services
Hospital Alcohol Team Bromley**
Substance Misuse
Bromley Well
Local Authority Services
Family Drug & Alcohol Court (FDAC) Bromley only
Job Centre (Bromley)
Housing Support (Bromley)**
Education
Schools
Family Support Worker
Third Sector
Bromley Living Well
Police
Criminal Justice System
Substance misuse support in Prison
Probation Service


Self/General Public Referral
Health and Social Care Connect (Glasgow)
Self
Universal Services and External Agencies
Other Social Work Services
Adult and Older people SW
Universal Services and External Agencies
Children and Families Hub (Bromley)
Education/Health
Third Sector
Universal Services
NHS
General Practice
Midwifery
Infant Mental Health Team (Glasgow)
Health Visitors & Family Nurse Practitioners
Community Perinatal Mental Health Team
Alcohol & Drug Recovery Services (HSCP Glasgow)
Adult Mental Health Services
Specialist Children's Services
Specialist Community Paediatric Service
CAMHS
Social Work (Glasgow) & Safeguarding Teams (Bromley)
Local Authority Services
Neighborhood Teams (Glasgow)
Family Centres
Housing Support Services
Education
Schools
Early Learning & Childcare (0-5)
Early Years Assessment Service
Police
Third Sector
Housing Support Services
Drug and Alcohol Service (BDAS) AKA Change, Grow, Live Bromley
Financial Support Services
Family Drug & Alcohol Court (Bromley)
Criminal Justice System
Criminal Justice Worker
Youth Justice
Children's Hearing System
Children's Reporter


Self-Referral
General Practice
NHS
General Practice
Community Mental Health Team
Specialist Eating Disorder Team
Trauma Services
A&E
Crisis Teams
Liaison Psychiatry
Adult Mental Health
Third Sector
Glasgow Association for Mental Health (GAMH)
LifeLink
Social Work
Mental Health Social Work


Points of Access for GIFT & LIFT Teams
Courts
Social Work Family & Children's Services
Fostering & Adoption Service