



“Falling Through the Gaps”

Looking for ways to fill the spaces
between mental health services for
children, young people and adults

Notes from SPN Study day 24 October 2003

SPN paper 5

Editor: Rachael Hetherington

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Foreword - The rationale for the study day

The Social Perspectives Network (SPN) is a network of professionals and service users of the mental health services. Its aim is to encourage and promote the use of a holistic approach to mental health that fully acknowledges and makes use of the importance of the social in the promotion of mental health and the treatment of mental ill health¹. The place of the family as the primary and most influential social network is therefore implicit in the philosophy of the SPN. While there will be many people for whom family is not currently the most immediately important social support, everyone has been a child. Family connections and responsibilities permeate our lives. More specifically, children and young people as well as adults have mental health needs. They suffer from illnesses and they are involved when a member of their family suffers from an illness.

It was therefore right that the activities of the SPN should recognise the importance of the family and the importance of the needs of children as part of the family and as members of society. It was decided to focus the fourth SPN study day on this area.

Families do not fit neatly into service categories. The needs of families cut across the normal boundaries of agency structures. In the normal course of events, at any one time the members of one family may be engaged with many different agencies and services, and this is multiplied if there are social problems of any kind. In addition, the circumstances of a family and the needs and status of the family's children are constantly changing over time. As children grow older they move through age-related service structures; from primary to secondary school to higher education or employment, from child to adolescent services to adult services. Every boundary crossed makes demands on both parents and children to adapt to a new service system. The natural process of family life, the diversity of demands and the changing nature of needs over time, challenges the ability of society to provide effective services. The family shows up the weaknesses of social structures.

The centrality of the family group to social wellbeing means that services need to be able to respond with a family centred approach, but services increasingly tend to be structured with very specific remits, and this inhibits flexibility and work across agency boundaries. Providing family centred responses is not easy for agencies that have been set up to work with individuals.

Communication and co-operation between agencies are therefore of the highest importance. However these aspects of agency functioning are repeatedly highlighted as failing. When successful communication is so consistently found to be a problem, this suggests that, although structures may help or hinder, there must be an intrinsic problem over communication and co-operation between agencies. In other words, it is likely that professionals are not simply failing, for some yet to be discovered reason, to do something both obvious and easy; they are failing to do something complex and difficult, which may in some cases be made more difficult by some aspects of agency structure.

The people who know most about this are the service users, who can see the failures and have the best view of what needs to be done. However service users do not necessarily have the power to make the connections that the services fail to make. Although the voices of service users are more frequently heard than used to be the case, it is still hard for them to influence the wider developments in practice and structures that make communication between agencies problematic.

¹ For a fuller account of the SPN see the SPN web site, www.spn.org.uk

In choosing to focus a study day on the family and the mental health needs of children, the SPN therefore decided that the working together of the mental health services as a whole, for children, adolescents and adults should be the object of study.

The choice of focus

It was decided that in focusing on inter-agency and inter-disciplinary co-operation, the study day should work on selected problem areas, as a means of developing practice strategies that could be specific and grounded in local realities. The problems chosen were those that demonstrated the gaps between services. They present a range of different challenges to the coherent provision of services.

The topics chosen for the study day were the problems of transition from services for adolescents to adult services; the needs of children who are victims of crime; and the needs of children and parents where there is parental mental ill health.

The transition from adolescent to adult services

The services for adolescents offered by Child and Adolescent Mental Health Services (CAMHS) are grounded in an awareness of the family context in which children and young people function. This awareness, derived from psychological knowledge common to the professionals involved, is reinforced by the fact that legally adolescents do not fully become independent citizens until the age of 18. The legal independence of adolescents from their parents steadily increases during their teens, and the civil status of adolescents is quite equivocal, but there is a social expectation that up to the age of about 16 or 18 young people need the context of a family group. Because CAMHS is concerned with children from their earliest years, their concept of the needs of children and young people is predicated firstly on the fact of developmental change over time. Secondly on the fact that a child or young person is both an individual and member of a family group. This is a very different conceptualisation of needs from that of the adult services where the importance of the service user as an individual is paramount. There are therefore inherent problems in the transition from one service to another. These problems influence not only the practice of individuals but the ways in which budgets are structured, service boundaries fixed and priorities decided.

In the summer of 2003, the government targeted the problem of the provision of these services, and extra resources for CAMHS were announced. The SPN decision to study this aspect of the services was timely.

Children and young people who are victims of crimes

Children may suffer from crime as the result of being themselves the target of theft or aggression, or at second hand when their parent or carer suffers. Frequently children will be present at the time that their parent is attacked, but their needs are not always separately recognised. *Victim Support* has found that it is very difficult to find agencies or resources to meet their needs. Both CAMHS and the Children and Families services of the SSD (Social Services Department) are too over-stretched to provide help in any except the most extreme situations. This is a prime area for preventive work, where there is an identified group for whom a relatively low level of input could make a very large impact. At the moment for these children and young people there are more gaps than services.

The needs of children and parents where there is parental mental ill health

The working together of services for these families has been recognised as a problem for decades; it was the subject of a conference of the National Association for Mental Health in

1966², and the same problems were being identified and discussed at the Seiff conference in 1998³. It is possible that there was some improvement after 1970, with the introduction of generic social work, which reduced inter-agency boundaries, but if so, this was lost again when specialism in social work was re-introduced.

Communication between services for these families is complicated by the divisions between health and social services and, within both health and social services, between services for adults and for children. Adult mental health services work with the individual, and their focus is on the parent. The SSD Children and Families services work within a legal remit of child safety and focus on the child. CAMHS would focus on the family, but when the child is not the 'patient', they are unlikely to be involved. Professional anxieties about crossing agency boundaries combine with inflexible budgetary restrictions on resources to increase the difficulties. Research has shown that the result for service users is likely to be a fragmented and confused service⁴.

The format of the study day

The SPN is a network for practitioners (as well as service users and policy makers) and values the knowledge, skills and experience of professionals in the field. It is one of the tenets of the SPN that there is a great deal of expertise already available that should be validated and that a great deal can be achieved if workers have the opportunity to share their experience and insights. While workshop participants need to have the time and the opportunity to hear about new research, they need equally as much time to discuss new information provided by research, to learn from each other's responses to it and to evaluate its relevance. Adequate discussion time is important, and the learning from a study day is expected to come as much from the input of the participants in discussion as from the formal presentations.

The format of the study day was designed to promote learning through presentations followed by discussion in small groups. The programme of the study day is given in Appendix A. The focus of the morning was on identifying the problems and the barriers to providing integrated and flexible services. The discussion groups of the afternoon were focused on the remedies and solutions that could be found within the services of the participants and within their range of influence – what, in practical terms, they could do.

The following sections of the report give summaries or the full texts of the presentations and summaries of the group discussions.

The participants in the study day

The subject of the study day was topical. The day was over subscribed, and a waiting list was kept to fill vacancies due to last minute cancellations. 72 participants attended. They were drawn from a wide range of agencies within the mental health services, from services for adults, adolescents, children and families. Non-Governmental Organisations (NGOs) were represented, though there was a preponderance of statutory agency members. There was an under-representation of participants from the Children and Families services of the

² NAMH (1966) *Proceedings of the Twenty-second Child Guidance Inter-clinic Conference, 1966*. National Association for Mental Health, London.

³ Sieff Foundation (1997) *Keeping Children in Mind: Balancing Children's Needs with Parents' Mental Health*. Michael Sieff Foundation, London.

⁴ Green R, Hyde E, Katz I, Mesie J, Vincenti O and Worthing D (1997) *Long term Problems Short term Solutions – Parents in Contact with Mental Health Services*. NSPCC, London; see bibliography in Appendix D for further reading.

SSD and from the child welfare services in general. In part this reflects the divisions between health and social services. The organisers contacted services for children and families, but the health service basis of the SPN seems to have reduced the appeal of the programme offered. It also reflects the primary pre-occupation of the SSD services with child protection, which leaves them with no time to focus on service users where protection is not the central factor.

The greatest lack in the study day was the very low level of service user involvement. The day was greatly helped by a presentation by a carer from a service user perspective, but there were very few service user participants in the study day. The SPN has still to develop an effective network among the service users of CAMHS and of the child welfare services.

Welcome by the Chair: introducing the social perspectives approach

Judy Foster, Co-Chair of the Social Perspectives Network

Why the Social Perspectives Network?

Three years ago there was a fear that the proposed integrated services in mental health might lead to medically dominated services and the view that a person has their own unique narrative embedded in their social and psychic experiences might be ignored. Through email communication, a website, national study days and the regional networks now developing we want to stimulate critical thinking and discussion to encourage those involved in delivering and receiving services to have confidence in what a social perspective can offer. We can all contribute to the resolution of someone's mental distress. SPN aims to provide what Donald Winnicott thought of as a transitional space for interested people to use for creative thinking. With the radical changes mooted in children's services through the transfer to the Department for Education and Skills, The Green Paper and the National Service Framework, someone needs to offer a supportive facilitating environment to underpin this growth.

Today's study day really epitomises what SPN aspires to: a group of interested, committed people with a variety of experiences, skills and knowledge – YOU; half a dozen to share specific aspects of living with mental distress in families; space to reflect on what you have heard, with time to discuss and plan ways forward. We are looking at the risk of falling through gaps between children's and adult services, between being a child and a carer and between being inside or outside society, particularly refugee children, black and other minority ethnic groups.

What will be the outcomes from the day? It's not easy – there are no pat answers, but we want to write up today's thoughts and circulate them back to you and your groups. On your side, we hope you will set up seminars and discussion groups for carers, foster carers and residential staff, Connexions and Youth Employment Workers to help them help the young in this fragmented world.

Opening Address: the Themes of the Study Day

Dr Judith Trowell

Dr Trowell opened the discussions of the study day with an outline of the latest government initiatives relating to services for the mental health of children and young people.

The National Service Framework and the Green Paper

The NSF, published in April 2003, sets out plans for the better co-ordination of relevant services and the development of CAMHS. It calls for partnership between the health, education, social care, and youth justice services and services run by voluntary organisations. It sets out specific situations when working in partnership is essential, and outlines plans for co-operation over commissioning. It calls for multi-disciplinary training and for training in mental health for generic workers.

The government green paper, Every Child Matters, published in September, envisages a new structure for the integration of services for children and young people. It creates the new and important role of Children's Commissioner and it plans for the development of Children's Trusts, which will include many of the services for child and adolescent welfare that are required by the NSF to work in partnership.

Children's Trusts will be based in the local authorities and will include key services for children and young people, viz: 'Community and acute health services – such as community paediatrics, services commissioned by Drug Action Teams, teenage pregnancy co-ordinators, and locally commissioned and provided Child and Adolescent Mental Health Services'.

Thus CAHMS is placed within Children's Trusts, and will become more closely identified with the structures for child welfare and further separated from adult mental health services.

The Trusts will have 'a single planning and commissioning function supported by pooled budgets....developing an overall picture of children's needs within an area'. The integration of objectives is expected to include 'arrangements for addressing interface issues with other services, such as services for parents with mental health problems'.

These are major changes, requiring very considerable readjustments for all levels of management and from front line practitioners. There are great opportunities, but the demands on our flexibility and responsiveness will also be very great.

Dr Trowell referred to figures from recent research, and figures published by the Department of Health in July 2003, which show the extent of mental distress among children and young people, particularly those in the care system.

There is a planned increase in capacity of CAMHS of ten percent each year for the next three years, with the intention that 'all areas are delivering a comprehensive Child and Adolescent Mental Health Service by 2006'. There is also an expectation that 'people working in universal services should be able to identify children who may need help' and that 'trained mental health workers need to be able to support workers in other agencies'.

This increase in capacity at the same time as a requirement for the provision of more support from CAHMS for other workers will require a substantial increase in trained staff and the green paper commits the Government to addressing 'the continuing and additional training needs of the CAMHS workforce'.

These ideas offer excellent opportunities for constructive developments, and the new post of children's commissioner is a welcome development. But the current skills shortage is immense and it is hard to see how an increase can be achieved within the suggested time table.

The conceptual framework of attachment theory has provided a language that policy makers, managers and the Law can respond to, and that enables them to take significant relationships into account. However, it has the disadvantage that it may be seen as all that there is to be considered. We work with children who have no attachments and we struggle with the issues for them. Moreover, parenting is a complex activity, and it entails more than physical care, dental check ups and school attendance. CAMHS works in an area of very complex needs that require flexible responses. How services and practitioners will manage yet more structural change is the problem.

'We may not yet be where we'd like to be but at least we're no longer there any more. More importantly we're on our way somewhere.'

Sheena Foster, carer, Vice-Chair of the Northern Region Committee of Rethink

I have three sons, two of whom have a diagnosis of schizophrenia. The son who was most severely affected is called Tom. I cannot speak for my son; he has his own voice - what I can do in the time available is to look at the care he received in CAMHS nine years ago and in particular the transition into the Adult services.

First there needs to be some understanding about the effect of such a diagnosis on the family. It's not like a nut allergy where all the family can pull together by identifying suitable foods. All family members suffer and for our family there was a long period of total disintegration. This is not an exaggeration. One of my sons was sectioned for 5 years, we've had two suicide attempts, at one point my husband left and my youngest son developed a passion for death cider. It has not been an easy journey. Above all we were lucky to have a Young Peoples Department (YPD). I don't believe we would have survived as a family otherwise. At all times my son was treated with dignity and respect. He was informed about his medication -the dosage and side effects, he was encouraged to take responsibility for his illness by recognising factors that caused him stress and to assert his rights by appealing against section. He was listened to at all times - his voice was heard.

As a Carer I was regarded as an important member of the team. I had support 24 hours a day 7 days a week, and weekly consultations with the psychiatrist and my son. I often refer to this as a triangle of care. As he approached 18 I was gently encouraged to recognise that he could withdraw his consent to my involvement and therefore I needed to respect this right he had as an adult. On reflection significant work had been done with me. His keyworker helped me identify when I was slipping into 'mother mode'! That time can never be taken away from us but I believe it was the basis for the relationship I now have with Tom. It was also the foundation laid down for me to understand other family members.

Despite this continued support on two separate occasions when in an adolescent secure ward and again when in a secure adult ward I was told this may be as good as it gets. I couldn't give up. Through attending conferences and workshops organised by Rethink I had met people who had never given up. I knew my son before he was ill and somehow he was still there. Sometimes we lose sight of the person and treat the illness but the person has to come first. It takes a great deal of courage and determination to live with and recover from a severe mental illness and that's not acknowledged enough. My son possessed both these qualities before he became ill, otherwise why would he have escaped from the YPD more than twenty times - a record I believe! That's another take on the label 'non-compliant, difficult to engage with the services and having little insight'. Tom had all the badges pinned to him until he bled.

The fact that I was listened to throughout our time with the YPD made me trust the people who were working with Tom and myself. Tom felt valued. We have to be able to trust the services and that's difficult if we don't feel our voice is being heard. If we trust the services

we respect the people who work in them and are able to be more honest and open. That's a working partnership.

The approach to Tom's transfer to the adult services was filled with apprehension. I'd asked that the people who were to be responsible for Tom's care in the adult services be invited to the YPD so we could meet them. This was an eye opener for me. The staff from the YPD sat on one side of the room and the adult services on the other, slightly bemused when the occasional adolescent in the unit approached them asking why they were there! It was quite obvious that they were unused to being asked questions.

Tom's first meeting in the adult services was in a room full of people - no gentle introductions there, then. I had to ask them to introduce themselves. Sometimes the carer's voice needs to be heard and though my guts were churning I hadn't finished! "How do you expect to develop a therapeutic working relationship with my son if the only time you see him is with a room full of people?" I had to repeat this question three times before I received an answer but I was so lucky. For a short period of time Tom and I met with the psychiatrist once a week as we were used to doing.

However four months into our time with the adult services Tom said, "They don't care about me anymore do they mum?" and that was his voice. I mentioned to his key worker that he was increasingly disorganised and chaotic and nothing was done, the crisis team found him deeply distressed and did nothing. Finally I had no choice but to call the police and he was admitted to hospital. At that point Tom withdrew my right to be involved with his care and refused to see me. This lasted for 8 months. All I could do was write a letter telling him I still loved and cared for him but I had to respect his choice. The first time he had leave from the hospital he came round and I was faced with a polite and sensitive young man the person I always felt Tom would become. The psychiatrist apologised and admitted that the adult services had "got it wrong". Tom began to work with the Assertive Outreach Team (AOT) who, under his guidance, are happy to work with me. Finally we have another triangle of care but he could have fallen through the gap.

Tom continues to work with the AOT and continues on his journey of recovery. We have laughed together and cried together as he tells me about his time in hospital. He shares his "bad thoughts" with me so we both understand. Sometimes he doesn't know I'm his mum and that's where he gets confused. It's apparently a common delusion but nevertheless quite hurtful. I do however feel privileged that he's shared this with me. Our journey continues. It's a learning journey.

There are two final points I'd like to make. We're talking about the voices of young people and one voice is often overlooked. I mentioned earlier on that my youngest son had developed a passion for death cider. He was also affected by his brother's illness and began to fail badly at school. He suffered too. He was also a young carer, which I had failed to recognise. Two years ago he became very angry with me. "You don't know what it's been like for me. When I'm walking down the street with our Tom and he's only got his jacket on and no T-shirt I don't shout at him. I say Tom, will you please fasten your jacket up because I don't want you to catch cold." It was the note of pride in his voice that made me realise that we hadn't shared our stories. This took some time but finally my youngest son declared, "Tom has his degree, it's about time I got mine." I knew exactly what he meant. Knowing Tom is on his recovery journey has enabled my youngest son to go down to London to university.

Lastly I'd like some consideration to be given to carers. Hearing their voice is also important but rarely acknowledged. The average duration of untreated psychosis is 18 months in this country. In that time the family, possibly without realising, has changed in order to adapt to the behaviour of the unwell member. As soon as help has been obtained everything is

naturally focussed around the person who is ill. The main carer also has a story to tell but this is overlooked. Faced with feelings of anger, guilt, shame and fear the main carer continues to hold the family together. I was told I needed to "stay strong". I've recently been on a five-session carer course run by Rethink, and staying strong has repercussions. After the first session, when all is well with our family I was up all night sobbing. Nine years of tears were shed. I had not realised the impact of the illness upon myself. Encouraging a carer to tell their story is enabling their recovery and in turn effectively enables a service user's recovery. Only when carer's voices are heard will the system recover.

Sheena Foster finished her presentation with the quotation (used as the title of this presentation) from an Observer interview with the South African write André Brink. 'We may not yet be where we'd like to be but at least we're no longer there any more. More importantly we're on our way somewhere.' It is a statement of affirmation and realistic hopefulness that has helped her and that may help others using or working in the mental health services.

‘Not working and not working together’: A study of services for children who were subsequently placed in secure accommodation

Tina Foster, CAHMS Development Officer in Teesside

There are two components to this study: interviews and case audits.

The interviews with young people and their families

The young people were interviewed either in the secure unit or sometimes in a follow on placement. Where they were interviewed depended on the length of time it took to get consent. Almost all the parents were interviewed in the family home. The focus of the interviews was to gather their views on the services that had been provided to them prior to placement in secure accommodation.

The file audits

Secondly, following the consultation a case audit was undertaken with the key worker and any other professionals who were either currently or previously involved in the case were invited. In reality there was often only the key worker which may explain some of the difficulties we then went on to identify in the study. The audits were undertaken in the main by my colleague, and myself and we were joined on some occasions by a colleague from education. These audits were designed to look at the pathway the young person had taken through the services to reach the secure unit.

The following quotation is taken from the Green Paper - ‘*Every Child Matters*’ and describes the lack of co-ordinated services that contributed to the death of Victoria Climbié. We saw many parallels in this audit with the Climbié report.

"... some of the problems are of long standing. The common threads which led in each case to a failure to intervene early enough were poor co-ordination; a failure to share information; the absence of anyone with a strong sense of accountability; and frontline workers trying to cope with staff vacancies, poor management and a lack of effective training."
(Department for Education and Science (2003) *Every Child Matters*)

The next quote is from an exasperated social worker
" I don't know what its called but its not working together!"
(*Social Worker*)

The young people themselves

- 13 young people came from three of the northern local authority regions - North East, North West and Yorkshire & the Humber. They came from eleven local authorities
- 11 were described as White British, one as White European and one as Asian
- 6 had statements of educational need
- 11 were looked after prior to placement in secure accommodation
- most were aged 14 – 15; the average age was 14.7
- the young people looked after had experienced on average 11 placement moves. One young person had experienced 25 placement moves in two years

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- 7 had been looked after out of area before secure placement
 - referrals to specialist CAMHS had been made for twelve of those interviewed at some point in their lives, although half of these had either not engaged with the service, or were not perceived as being in a settled placement.

The interviews with young people and parents

There was a sense of real frustration at the lack of early support. It is difficult to say whether earlier intervention would have reduced the need for secure accommodation although this was certainly the perception of both the young people and the parents.

The young people were also very clear that moving them about without talking to them or explaining things increased their resentment and escalated their angry behaviour.

The main thing that both parents and young people highlighted as being very helpful to them was the relationship that they built up with individual workers. Outreach workers were often cited as helpful. However, these relationships were often short lived due to either short-term interventions or rapid staff turnover.

There was a high degree of consistency about what the young people wanted:

- They wanted staff and carers, or other children, as mentors who had been through similar experiences and who could relate to them or empathise with them.
- They wanted care placements that could cope with them and manage their difficulties, the need for firmer or clearer boundaries in residential care was also highlighted by both parents and young people.
- They wanted to remain in their placements- one young person telling me that what he wanted was ONE placement, just ONE placement.
- They wanted more information and consultation with the social workers and an explanation about what was going to happen to them- one young person describing it as 'being scary'.

There was a strong sense of resentment about the way they were being moved about and the fragmentation of decisions and people who were in contact with them. Despite their experiences they were saying strongly that they wanted to be in closer contact with their family and friends. At times an increase in distance between the young people and their families coincided with increased levels of self-harm.

Quite a few of the young people and parents praised the secure units they were in. One young person summed up his distress about previous services and how the secure unit differed in approach. "*They (services) should do things before they have to - if I'd had the same kind of help then that I am getting now this wouldn't have happened. I feel like people care now and they didn't before.*" This young man was 14 years of age and in the secure unit on welfare grounds.

Our most significant finding is about the drift in initial planning for the provision of support and early intervention that was evident (with hindsight) in all the cases. In every case we felt that there was an opportunity to intervene earlier, that was not taken. Each agency appeared to be working within their own boundaries or parameters with little sign of working together or jointly. There were missed opportunities to spot or early-identify the signs of later difficulties. We felt that this indicated a lack of knowledge on the part of several key agents. There was no evidence of information being shared in order to make jointly planned arrangements

There was a real sense of the agencies not wanting to get over-involved. Short-term interventions were delivered inappropriately, cases were closed or not responded to urgently, and so forth. When the young people were moved out of the area there appeared to be no

real urgency about following them up or working out how to bring them back quickly. This led to a lack of worker-continuity, which in turn led to a loss of understanding about the history of the case.

There were several examples where more could have been done earlier to help with the trauma and loss that the young people had experienced. We felt that this could have prevented some of the placement breakdowns. Some of the issues presented in the early histories were about parenting styles, attachment and witnessing domestic violence. On several occasions we were told (with hindsight) *"I don't think that (mother) was really committed to (child)"*.

When we looked at the history of a case, schools were the first place where difficulties arose. At this point social services or CAMHS would not be involved. When there were further concerns, social services would involve their Community Support Teams. These would be offered for fixed term periods. We felt that these teams often missed some of the early warning signs, and that this was perhaps a training issue.

We saw few signs of joint agency assessments or joint agency action plans. Each agency followed its own formats and appeared to be working within their own terms of reference. In only one case was there was a very good example of a joint agency action plan, but the workers involved agreed that it had been put together far too late in the process.

In several cases there was a war of words going on about whose job it was to get involved in the planning of the case. Steamy memos were going back and forward between social services and CAMHS in particular. Rather than jointly holding onto the work it felt like there was a hot potato being passed back and forward.

We also found several examples where the Youth Offending Team (YOT) had been left holding the case, and where social services had closed the case and CAMHS and education had withdrawn. This was usually where there was a custodial sentence. Despite the complexity of the case, there was minimal information given to the YOT worker, who often appeared at a loss as to what to do. Joint agency discharge planning arrangements were not very evident.

There were too many examples of workers seeking unrealistic placement stability or seeking imaginary expert placements - usually somewhere far away and elsewhere. There was not enough ownership of the difficulties in the locality.

Many of the young people had been subjected to a range of psychological assessments often with very little outcome on interventions. There was often a lack of clarity about funding for therapeutic interventions whilst in secure or out of area placements although some of the units had developed contracts with local forensic services. We also found that there were difficulties for young people who were presenting with extremely high risk taking behaviours but who did not have a history of offending. These young people were often caught between the interface of CAMHS and Forensic Services. This issue warrants further investigation as although the funding of therapeutic interventions for young people placed outside of their 'home' area was not a key area of investigation for this work, it was a point raised many times within the audits.

Most of the young people were not presenting 'acute' behaviours in the secure units, although we did find at least two examples where the secure units had difficulty coping with the level of violence or self-harming behaviour. One young person who was on a Secure Order on welfare grounds was given four weeks notice to quit the unit (which was in another

area of the country) and the social worker, as one would expect, had great difficulty in finding another placement.

There seemed to be a great 'heaving of sighs of relief' when a secure placement was found and not enough pro-active forward planning for getting the young people out of secure, especially on a multi agency basis. Individual workers were often struggling to find placements that could meet the young person's needs with very little evidence of agencies working together to plan to return the young person to their home area.

One young person who I visited on the 21st December was due to leave on the 23rd December and still did not know where he was going to be for Christmas. The social worker had been attempting to find him a placement but again this planning was left to an individual worker without other agency back up.

Workers in the agencies were often 'at each other's throats', and we felt that this was due to the lack of senior manager strategies for dealing with the cases. There was little evidence of the national good practice contained within the CAMHS Innovation Projects or the current specialist or treatment foster care services.

Because we knew how these dedicated services and arrangements were working well elsewhere, we could recognise that the absence of dedicated support services for the looked after system as a whole, were leaving 'significant holes in the net through which young people were falling.'

The key findings

The findings have identified gaps in multi-agency working for this group of young people.

To meet the needs of this group of young people effectively there need to be effective co-ordination systems and jointly commissioned services in each area. As the needs of these young people were complex no one system was able on their own to meet them. Often key workers left holding the cases felt ill equipped to deal with the situations that arose in the young persons lives without assistance from others. The development of a multi-agency co-ordination and oversight body, perhaps with a commissioning element, might be one way to ensure that the needs of the young person rather than individual service boundaries are at the forefront of service provision.

We also saw evidence of poor knowledge and lack of joint agency understanding especially in relation to mental health. Multi-agency training initiatives need to be prioritised and developed to meet this gap.

The main learning from the CAMHS Innovation Projects was that it is a whole systems issue - you need to raise the capacity and skills base of all the parties in the system - foster carers, residential staff, social workers, fostering link workers, placement managers etc. Community Support Teams and the other early intervention services also have a key role to play in ensuring that there is appropriate joint-agency working

The main recommendations:

- There is a need for a multi-agency strategy in each area to consider the needs of this group of young people. The most obvious forum for the development of such a strategy would be the multi-agency CAMHS strategy groups in each area where commissioning issues could also be discussed.
- Young people themselves want to be better heard and involved in the development of appropriate services.

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- Treatment Foster Care offers a potential solution which should be considered and evaluated.
 - There need to be better agreements about where and when joint agency working is appropriate. For example, joint targets for responding within a set time could be introduced.
 - Drug Action Teams and health promotion services have a role to play that should be considered.
 - Attention should be paid to the obvious transition points where crises could emerge - school changes, placement changes, etc.
 - Consistency and flexibility of worker involvement would add to the potency of the services.
 - The children and the parents felt left out of decision-making, yet were key to many of the issues that later emerged. The family needs to be consulted.

Bridging the gap in mental health - developing ways forward

Keren Corbett, CAHMS regional development worker, West Midland NIHME

Background

- A number of reports have identified that older adolescents with mental health needs fall through the net, finding neither Child and Adolescent Mental Health Services (CAMHS) or Adult Mental Health Services (AMHS) accessible or appropriate to their needs and preferences.
- Transition between services is often problematic, and levels and styles of intervention can leave young people and their families feeling unsupported.
- Few specific mental health services exist for older adolescents.
- There is little joint training and joint working

The project purpose

To provide an opportunity to explore how CAHMS & AMHS can develop new ways of working defined more around need than artificial age criteria, and improve access to appropriate services for older adolescents.

The partners and their role

- NIMHE West Midlands & the CAMHS Learning & Development Centre (initiating the project, securing funding from the Modernisation Agency & disseminating good practice)
- Coventry University (undertaking evaluation of the pilots and gathering evidence of current service gaps)
- Coventry Primary Care Trust (pilot site)
- Birmingham & Solihull Mental Health Trust (pilot site)
- A project steering group drawing on other stakeholders and related work (to inform the project and broaden the impact of service development)

The process

- A baseline mapping of service provision in the pilots sites, the existence & quality of protocols or evidence of flexibility between services, shared care, transitions
- The appointment of a project worker in each pilot site
- Ongoing evaluation – Stage 1 report will be available after final consultation next week.
- Now aiming to link more widely with activity across the country

The research process

- 8 interviewees from CAMHs, AMHs - predominantly nursing focus but included a Consultant Psychiatrist and a Commissioner.
- Questionnaires – 39 out of 60 respondents - MDT.

-
- Literature review -combined to afford triangulation and validity of the data.

The results – quantitative

- Paucity of robust referral systems – ‘No adult services exist for Attention Deficit Hyperactivity Disorder/ Austistic Spectrum Disorder (ADHD/ASD), so why refer?’
- Poor Communication channels – ‘I know they exist on a managerial level, I don’t really know about a clinical level’
- Lack of service provision for young people suffering from ADHD/ASD – ‘I think it is a lottery’
- Assessment environments not conducive to effective engagement – ‘ becoming a patient is rarely in the long term interest of ‘troubled’ (as opposed to mentally ill) adolescents’
- Care pathways fundamental to transition arrangements – ‘clear recognition required of where general adults take over from CAMH’s’
- Welcome opportunity for further training – ‘yes, but don’t have time’

The results – qualitative

- Communication – Lack of formal networks, communication only occurring if there was a crisis. ‘It might be hard to get a secondary service – it really helps if you have schizophrenia’.
- Transfer arrangements – ad hoc, most positive being between practitioners who know each other. Most respondents requested a move away from definition by education status to a clinical focus based on diagnosis.
- Assessment skills – all respondents felt adequately skilled although all welcomed opportunity for shared CPD.

Areas of good practice upon which to build and develop:

- Robust community teams.
- Consistency of consultant psychiatrists.
- Committed staff.
- Increased use of atypical antipsychotics.
- Enthusiasm of staff to share learning opportunities.

Some of the questions we hope to address

- Is developing improved transitions CAMHS/AMHS doing it or sharing it?
- Or is it about sharing existing skills and services to ensure that all service users receive their ‘optimal’ journey
- Or is it developing something new?

Dr Trowell concluded the presentation by outlining the response that they had received from the research participants to a questionnaire and interviews. These described major problems with communication and a lack of formal mechanisms for promoting communication. Awareness of the needs of the family was very variable, though sometimes good.

Children and young people: coping with the psychological effects of crime

Ben Smith, Policy Officer, Victim Support

How many people are affected?

Crime against children and young people is widespread.

Children and young people are *twice as likely* as adults to be the victims of crime - and yet the majority of support services are targeted at adult victims. So Victim Support is increasing its emphasis on the needs of children and young people.

About half of all children attending school - and 70% of excluded children - are directly affected by crime. This is almost twice the rate of victimisation for the general population, which currently stands at around 30%.

Figures also show that half of these young victims are *repeat* victims of crime. Many of these children don't report offences and aren't offered professional support.

What's more children can also be *indirectly* victimised - for example, when a family home is burgled, or a child witnesses a violent crime.

The indirect victimisation of children can be just as serious as direct victimisation - and again, it's widespread. Crimes such as burglary can have a significant effect on children manifested for example, in changed behaviour, nightmares and bed-wetting.

Crimes committed against a family member or relative – such as a sexual assault on a parent - also have an impact. A study carried out in 1992, found that children who witness crimes against their parents or siblings were, invariably, traumatised by what they had seen. But crimes can also affect children who may not have any connection with the victim.

Children and young people can be seriously affected by domestic violence. In 2002, the charity, Barnados, reported that young people are present in the same or next room in nine out of ten cases of domestic violence. The National Children's Homes found that 87% of domestic violence respondents said that their children were aware of violence in the home.

Because *indirect* victims of crime are more hidden than *direct* victims, it's more difficult for services to reach them.

So if you add up the number of children *directly* affected by crime and those *indirectly* affected by crime, there's a very large number young people trying to cope with the effects of crime.

More research needed

A lot of research has been carried out into the effects of crime on adults' mental health. However, much less is known about how *children's* mental health is affected.

A family coping with crime – a story from the Witness Service

How professionals respond to a crime can have a profound psychological effect on children and their carers and a sensitive response can help reduce negative effects. Here's an example. While I was working in Victim Support's court-based Witness Service, I met a woman who told me that one evening, when visiting their friend, they were watching television in the living room and a man broke down the door bursting into the house. He was wielding a knife, which he held to the householder's throat and demanded money. Fortunately, he didn't injure anybody during the attack and he eventually left the house. The police were called – and an armed response unit arrived.

The son became very distressed after the crime. He was having nightmares, and couldn't get to sleep. At his nursery, he spent a lot of time on his own. He was frightened that the 'bad men' would come and break into his bedroom. Not bad *man*. Bad *men* - plural. To the boy, the bad men included the armed police. He was clearly terrified of them. For him, the whole event had merged into one, and he didn't distinguish between the criminal and the police.

Because the mother and son had only been visitors not residents they weren't viewed as the victims. This meant they weren't offered support. They didn't receive information about the case and weren't consulted on important decisions. They felt *excluded*.

The woman felt that she was left to cope with her son's distress and the disruption to their lives on her own, and that she had to seek out help herself.

When the woman and her son were finally recognised as victims of the crime, they were able to take a more central role in the criminal justice process, which the mother felt played an important part in resolving some of her son's psychological difficulties. They were also able to find out about restorative justice and Victim Personal Statements (VPS), which offer people the opportunity to describe how a crime has affected them psychologically, physically and financially.

For many people, writing a VPS is a useful – often *therapeutic* – experience, because it allows them to explain *to the authorities* how the crime has affected them.

When the mother explored the idea of the VPS with her son, he said that he would like a letter from the man that said "sorry". She was able to include this in her VPS on her son's behalf, and they received a written apology from the man. The woman described to me how she read the letter to the son in the garden and that afterwards, he sat very quietly for a long time, reflecting on what the man had said. It's her belief that the man's apology helped her son's recovery.

To summarise, this story shows that children can be indirectly affected by various crimes, including burglary, and that children – and not just adults - can have psychological reactions. It also shows that carers can be left feeling unsupported in trying to help children get the emotional help and mental health care they need.

Agencies should have basic awareness of how crime affects children
Victim Support believes that that all the key agencies who come into contact with children and their carers who've experienced crime – including healthcare providers, housing agencies, the police and the Crown Prosecution Service – need a basic awareness of the possible psychological effects of crime, so they can help young victims get access to help and support.

Young victims and carers have told us that it's difficult to get the mental health care they 'd like. They've found mental health services difficult to access and talk of long-waiting lists and an inadequate response from gatekeepers. To quote Peter Wilson, Director of YoungMinds: 'GPs often underestimate the problem and there's a tendency to under-diagnose and say the

parents are worrying too much. Sometimes GPs don't want to know...there's the question of who to refer the family to. There just aren't enough services.'

Impact of crime

Whilst we need to know much more about the impact of crime on young people we do know that just as with adults, psychological distress is a common reaction. A study showed that after crime 92% of children experienced some sort of adverse reaction. Common feelings are shock, upset, worry and fear, anger about what's happened, lost confidence, guilt and depression. For a smaller number of people, their psychological reaction goes beyond these feelings, and develops into a longer-term mental health problem.

Children and young people are still growing, and have considerably less life experience than adults. Unlike adults, they have less opportunity to choose the environment they live in, learn in and the people with whom they associate. They're vulnerable.

According to the Royal College of Psychiatrists, the extent of children's reaction to a traumatic event - such as violent crime - is influenced by how involved the child was in the event, by age, maturity and the degree of support from family and friends. For younger children, the distress will be made worse because they can't fully understand what was going on.

Impact of crime – example of homicide

How homicide affects children is an extreme example of how crime affects children psychologically, but many of the effects can be common to a range of crimes. Jean Harris-Hendriks, working with Dora Black and Tony Kaplan, found that children affected by homicide are 'the tip of an iceberg when taking into account all children who witness violence, including sexual assaults, in their own home.'

Children who have lost a parent to violent death can experience post traumatic stress disorder (PTSD). One research study found that, where one parent had killed another, about a quarter of children experienced moderate to severe PTSD, and that children who'd witnessed the killing were even more likely to develop it. The serious impact on children's health of witnessing a violent incident has been recognised by an amendment to the Children Act, where harm has been redefined to include *witnessing* violence.

Moreover, children who have experienced violent bereavement are more likely to be neglected after the crime by carers. Children suffer because they are unable to rely on parents for protection. Day to day life is disrupted. They experience fear, anxiety and helplessness. In these circumstances, it's essential that professional agencies that can offer support and healthcare respond swiftly and appropriately.

Dr Black stresses that traumatic experiences like crime affect how the child's brain develops. Children who experience traumatic events - such as crime - are more often affected than other children by PTSD, emotional and behavioural problems, academic problems, poor self-esteem and a reduction in empathy.

However, Dr Black also stresses that the negative effects of crime are reduced for children, if they are helped through trauma and grief. Factors which enhance and promote good mental health in the aftermath of a traumatic event - such as crime - include being provided with independent advocacy, being offered therapeutic help and being cared for by adults who are able to meet the child's needs and who themselves have help and advice at hand.

To cope with these negative effects children need to be able to put down roots in a stable environment; to continue their education supported by understanding teachers; and to retain memories and records of their earlier life and contact with important friends and relatives.

Victim Support

Victim Support helps young people affected by crime through its community-based service, chiefly by supporting carers who are helping their children cope with the effects of crime.

For example, one supporter visiting a household who had been burgled found that a seven year old girl was too frightened to go upstairs to her bedroom, which the burglar had entered. Over several visits, the volunteer, child and parents sat on the stairs. The volunteer talked with the child about her fears, moving gradually up the stairs with them until the child felt safe enough to go into her bedroom again.

Victim Support also provides a Witness Service in every criminal court in England and Wales. This supports young victims and witnesses who give evidence. Our staff and volunteers prepare children for the court experience by giving information about what to expect, and support them emotionally.

A third aspect to our service is our national telephone service, Victim Supportline, which offers information and referral to local services.

People don't have to report crimes to use the services, which are independent, free and confidential, and provided by trained staff and volunteers. They're equipped to help people cope with their feelings and to support them during the recovery process.

However, for the small number of people who experience a protracted psychological reaction, we aim to refer people to other relevant services. We aim to train our volunteers to recognise when an individual might be in need of more specialist help.

Because crime affects the whole individual, it's important for us to develop effective relationships with other local services so we can signpost people to the help they need.

Developing Victim Support's services

Because crime against children and young people is so widespread and has such a serious effect, we've rethought our community service.

We are now offering a two-level service. The *first* level carries on our present approach of supporting carers with children affected by crime. Our level *two* service offers more long-term support where the supporter works with the young person directly, liaises between services and acts as an advocate.

We've developed a Young People's Support Pack to underpin our work with children and young people. This is designed to help our trained staff and volunteers provide a consistent, quality service, and to let the child or young person tell their story. There are three age-appropriate sections (infant, junior and secondary) so that young people can describe what has happened to them, how they feel, and what they want to do about it, by using writing, drawing, talking colouring in or completing puzzles.

Some of our 400 local Victim Support services have developed special young people's projects. Take Victim Support Croydon, which launched its R U OK drop-in service for young victims and has received many more referrals than expected.

Meeting children and young people's support and healthcare needs

At Victim Support, we're concerned that the experience of victimisation is recognised as a discreet risk factor for mental health problems in children. The media often focuses on young people as *offenders*, and many mental health services focus on offending – either to reduce offending or to support offenders.

What's overlooked is the link between youth offending and victimisation. For example, being a victim of crime at 12 is one of the most powerful indicators that a child will offend at 15, and likewise, offending at the age of 12 brings a strong possibility of victimisation at the age of 15.

It's vital that we acknowledge that services need to be planned to take account of this close link, and that all mental health services for young people should build in a basic awareness of the experience of victimisation.

The Green Paper and the National Standards Framework (NSF) mention 'children in the criminal justice system'. Mostly though they imply children who have *offended*, or who are at risk of offending, rather than those who have been *victims of crime*. It's essential that the Government enable agencies to commission specific mental health services targeted at young victims and witnesses, as well as young offenders. It's also essential that these services are planned with the awareness that the same young people are often affected by *both* experiences.

We're now more aware that adolescents may wish, in fact, need to access a service, including Victim Support independently. Take the example of a fifteen-year old girl who was seen by our witness service. She'd been the victim of sexual abuse. Her mother - who was herself very seriously affected by what had happened - didn't acknowledge her daughter's experience. As a result, the girl felt isolated. She went to her GP for help, and was prescribed anti-depressants, which she found unhelpful. Unable to call on help from her mother, and feeling that the doctor's response was not what she wanted, she was unsure where to go for help. Adults are often too tied up in their own reactions to crime to help young people.

Conclusion

To sum up, Victim Support would like professionals who work with children and young people to have a basic awareness how crime affects them. We'd like to encourage all professionals to refer young people coping with crime to appropriate agencies, including Victim Support, and to help the children who experience longer-term psychological reactions to access appropriate healthcare services.

The impact of crime on young people has been overlooked for too long. Together we really can make a difference.

The Morning Discussion Groups

The participants were drawn from a range of different services and professions located mainly, but not only, in the north and north east of England. The aim of the discussion groups in the morning was to share experience of the problems that contribute to the difficulties in providing effective services, and that leave some families and young people without access to services. There were 5 groups with about 12 - 14 people in each group, and membership of the groups was allocated, in order to give a mixture of different disciplines, agencies and geographical location.

The groups were asked to identify the main gaps in services in their experience. After establishing the problems, they were asked to list up to four of the major obstacles to co – operation between agencies. There were differences of emphasis between the groups, but between them the group responses provided a wide-ranging view of the gaps in services and the difficulties of providing effective responses. The following summary is taken from the flip charts written up by each group.

The Gaps

There was a pervasive lack of specific resources. Sometimes the problem was a lack of services suitable for young people, with suitable services provided only for adults. Sometimes there were services for children and young people that did not follow through into adult services. Sometimes there simply were no suitable services.

- Services for substance misuse and serious mental illness are only provided for adults.
- Lack of provision for 16 – 18 year olds outside of adult wards/services.
- A gap between CAHMS and forensic services.
- Some resources are available for children but not for young people over 18. For example there are no adult services for Autistic Spectrum Disorders.
- Lack of services for children and young people with special needs, autistic children, children with ADHD.
- Lack of basic parenting programme.
- Lack of a service for young women who become parents.
- Some diagnoses are only treated in young people under 18.
- Lack of specialist placements, often leading to placement far from the child's home and family.
- Structures are not organised to cope with dual diagnosis.
- A particular problem where there is a dual diagnosis of learning difficulties and mental illness because of different age criteria between services.
- Different age groups need different services, but services are not flexible.
- Poor access for self-directed referral.
- Lack of services for adoption breakdowns.

All groups complained about the lack of resources for treatment. There are resources for assessment but much less for treatment. Getting a service depends on having a clearly defined diagnosis. Children and young people without a clear diagnosis do not easily get help. Even with a diagnosis, they have to fall into the right category. There are no accessible services for children who have been abused but are not, for example, young offenders. In general there is a lack of resources for people with mental health problems that are not regarded as 'major'.

The problems

- Structural barriers

There was a general feeling that too much was determined by structures. *'There is too much emphasis on structures, are the services relevant, are they what young people want?'*

Criteria for eligibility and protocols were not always helpful.

- Funding barriers between agencies prevent 'joined up' planning. Questions about 'who is paying' and 'whose budget is responsible' dominate decision-making.
- The variety of different health providers increases inter-agency communication problems and leads to rivalry and anxiety.
- The different priorities of CAHMS and the SSD lead to tensions between them.
- Some issues are not 'owned', and this leads to gaps in services, particularly if no agency has a statutory responsibility.
- In rural areas there are problems in providing accessible services.
- Services do not connect well across geographical boundaries, so that children and young people who move from one area to another can get lost.
- The contribution of the voluntary sector is undervalued. The voluntary sector has more flexibility and more ability to connect with 'hard to reach' communities and 'hard to reach' young people such as black and ethnic minority young people. There are continual funding problems for groups doing preventive work, who may be the best able to connect with communities who are suspicious of the mental health system.

The participants said they felt dominated by the system in their decision making. *'The starting point is the system rather than the individual - services are based on organisational agendas and not on need.'* The system uses diagnosis or other external matters (such as whether a young person was in full time education) rather than need as a means of deciding who should receive a service. Age determined cut-off points and the 'tier' structure are other factors that limit flexible and imaginative practice. The use of targets (by central or local government) skews good practice by imposing external priorities.

- Lack of resources

- The list of gaps in the services given on the previous page describes the shortage of resources.
- Existing resources are very thinly spread. There are long delays between referral and getting help. Long waiting lists, screening out and referring on give a message of lack of concern. If people miss appointments it is difficult to re-accessing services for them.

- Professional and inter-professional problems

- Professional roles create boundaries, and there are myths about other professions and rivalries that create further barriers. One group was particularly concerned about the dominance of the medical model, and the power imbalance within multi-professional groups. In some settings there is little chance to meet with other professionals to challenge the myths. The lack of opportunity to meet with other professionals leads to introspective practice, each attending to their own agency concerns.
- Workers are overloaded. This leads to an unwillingness to take on cases, and makes it hard to shift from crisis to preventive work. Struggling to meet acute problems means that the need to intervene early may be recognised, but can't be addressed.
- There is a lack of continuity and follow up (which increases the risk that service users will fall through the gaps).
- It is inherently difficult to manage transitions, but the requirement to 'label' a young person before they can access a service increases the difficulties.
- There is a need for an 'anti-ageist' practice that accepts the validity of young people's views and wishes.

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- Confidentiality can be made an excuse for not working together.
 - There is not enough time to talk to colleagues in other agencies and informal contacts are not valued or encouraged.

The participants also listed problems in professional practice that were not necessarily the result of external factors.

- Failure to accept that other family members have their own needs
- Failure to work with parents as well as the young person (which might be due to the fact that the parents did not want to engage with professionals).
- Undervaluing of the relationships between professionals, which are important to good practice and need to be attended to.

- Training

There is a lack of common ground between adult and child care workers. Professionals who work with adult mental health service users do not think about the children, child care professionals lack knowledge about mental health. Thus there is a need for appropriate training across all the services.

- Time for training should be a statutory obligation.
- There should be a core training for all mental health workers.
- Training should include mental health promotion and the importance of holistic approaches to physical and mental well-being.
- CAHMS staff have training needs in relation to Tier 4 competencies.
- Teachers and other professionals need some training in mental health issues relevant to children.

The groups were asked to limit their final statement to the four most fundamental problems in communication and inter-agency working, resource problems. They pointed to:

- Lack of communication between professionals in different agencies and/or disciplines.
- Lack of joint, multi-agency training.
- Problems over professional boundaries and the dominance of the medical model.
- Lack of shared targets and joint ownership.
- Lack of resources.
- Lack of an appropriate allocation of resources.
- Inflexible organisational structures.
- Prescriptive targets set by the national service framework.
- The inflexible use of diagnosis as the only access to services.
- The pace and volume of 'top-down' change.

‘Bridging the gap’ between adult mental health and child care services

Marie Diggins, Project Manager, Social Care Institute for Excellence

Introduction

I have been a qualified social worker for the past 15 years. I started work as a local authority social worker in a generic team and in 1992 following the implementation of the Children Act 1989 and the NHS and Community Care Act 1990 my authority reorganised and I became a specialist mental health worker overnight. Just like that!

Later as services became increasingly specialised I became a social worker and then a manager in a multi-disciplinary Community Mental Health Team in the same borough.

When talking about families where there is a parent with a mental health problems it cannot be said that generic social work got it all right, but following the move to separate adult and children’s services it quickly became apparent to me and others that families did not divide in the way that services had.

For example a mother with depression seeking help with her 3 year old could be sent back and forth between services whilst the different specialist teams were deciding what was the primary difficulty? The mother’s mental health? Or the child’s need for a nursery placement?

This unnatural division and the impact it was having on families was the beginning of my interest in achieving practice change in this area. I now work at the Social Care Institute for Excellence (SCIE) in the practice development team for four days of the week and on the 5th day I am seconded to work in a London Community Mental Health Team (CMHT).

The Social Care Institute for Excellence

SCIE is an independent organisation created in response to the government drive to improve quality in social care services across England and Wales. The organisation is 2 years old. SCIE’s main function is to draw together evidence about what works well from a wide range of sources including the expertise of service users and their carers, formal research and practice knowledge built up by staff in the field. It then translates this knowledge into materials that are usable and useful for example into Practice Guides, Position Papers and Practice resources.

SCIE in partnership with health and social care workers is in the process of developing a national network for those people working with parents with mental illness and their children and I will say more about this at the end of this presentation.

I have been asked today to talk about positive developments in the way that child care and adult mental health services work with families where there is a parent with mental health difficulties.

I plan to do this by:

- Firstly giving some background about identified need and why workers and services need to work collaboratively with each other and with families
- I will then describe what gets in the way of working together

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- I will follow this with some examples of how the government and local agencies have tried to overcome these barriers
 - And finally I will tell you about a new project starting at SCIE

Identified need – background - why this is important

In determining identified need we have a good starting point in the amount of research undertaken in this area over the last 20 years or so.

It is safe to say that research and enquiry reports have established the links between parental mental illness and child welfare and the need for mental health and children and family services to work together collaboratively to meet the needs of families.

Some of this information has been helpfully summarised in key publications some of which link to training and practice guidance.⁵

There is not time here to go into the research in detail but I want to highlight two areas that have been established through reviews of the literature to date:

1. The potential impact of mental illness on parenting and on the child

The following extract from *Crossing Bridges*⁶ captures the scale of potential need and the potential need across time and generations:

'Between one in four and one in five adults will experience a mental illness during their lifetime. At the time of their illness, at least a quarter to a half of these will be parents. Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health. Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting impinge on adult mental health. Furthermore, the mental health of children is a strong predictor of their mental health in adulthood.' (Falkov, A (1998) *Crossing Bridges: a Reader for managers, practitioners and trainers*. Department of Health)

This highlights the key areas of relevance and the inter-connections between mental illness, parenting, and children. It also demonstrates the links over time (childhood to adulthood) and across generations.

It is important to emphasise that it is not inevitable that children whose parents have mental illness will experience difficulties, however, psychological and social adversities associated with adults with mental illness (e.g. impact of illness on parenting; family discord and disorganisation; poverty and housing problems; disruption in childcare and schooling) will increase the likelihood. (Webster, J. (1992), Stiffman, A., Jung, K. & Feldman, A (1988), Hugman, R and Phillips, N (1993), Darton, K, Gorman, J., & Sayce, L., (1994), Rutter, M. (1966))

⁵ See Appendix C for the handouts that accompanied this presentation. See section E of appendix C for the references.

⁶ *Crossing Bridges* is a training manual and supporting Reader published by the Department of Health in 1998 (authors K Mayes, M Diggins and A Falkov).

2. Service User Perspectives

Parents and children want timely and appropriate understanding and support based on (different) needs of individual family members, sustained over time but varying according to prevailing circumstances.

Studies have shown that the responses of professionals to mental distress in parents tends to be overwhelmed with a concern, either for the well being and safety of the children, or for the mental health of the parent as an individual. There appears to be a lack of attention to the role and needs of parents with mental health problems **as parents**. And it is sometimes unclear as to which specialist worker would see this as their domain?

There have been a number of studies that have considered what parents and children want for themselves and for each other, there is a summary of this information taken from Crossing Bridges in your handout (see appendix C).

Barriers to collaborative working

Before going on to look at some positive practice examples I want to highlight three things which act as barriers to collaborative working.

Discrimination

Gender, race, mental illness and parenthood each carry the risk of discrimination and oppression. However, these adversities are greatly magnified when they occur together within individual families (Darton, K., Gorman, J. & Sayce, L. (1994). For example, black women are particularly likely to have their children taken into care following a diagnosis of 'mental illness'. One study by Barns found 80 per cent of black mothers with children in care were referred for mental health reasons, as compared to only 20 per cent of white mothers. Barns (1990)

Specialisation

The organisational response to the Children Act (1989) and the NHS and Community Care Act (1990) was for an increasing separation of services within agencies. Since the move to specialist ways of working there has been an increasing challenge for social workers and other professionals to hold together the different aspects of services users' lives in both their thinking and their practice.

The increasing specialisation in health and social care has had benefits for example the opportunity for in depth training in one area but has also limited the 'breadth of view' of the same professions.

For example adult workers attend to the needs of their client as an individual whilst being unable to see the client as parent and her dependent children. In turn, staff in children's services work with children and their parents/carers directly but with insufficient emphasis on the mental health needs of parents and the potential adverse impact on children.

On the ground or in practice it can feel like there are a number of obstacles to overcome when trying to work with other specialist teams. There can be a lack of understanding and knowledge about each other's specialist area of work. Different IT systems, different budgets and different referral criteria and thresholds for intervention can all make it difficult to get the needs of the individual and the family recognised and supported. This can leave parents and children stuck in the middle waiting for someone or something to bridge the gap.

The impact of increased specialisation has emphasised the importance of ensuring effective communication and collaborative working within and across child care and mental health agencies.

Policy and operational frameworks

We do not have a broad based national approach to raising standards and improving outcomes for individuals and their families, this does not exist. Instead we have an increasing number of national strategies and frameworks that are aligned to core specialist services.

The difficulty here is that families do not divide in the way that professionals do and the challenge facing managers and practitioners is to pull out relevant points and approaches from each of the core areas and translate these into family orientated policy and practice locally. Sorting through the muddle can lead to a fragmented and diluted response for families with practice guidance that does not have a 'must do' element.

National strategies and frameworks in their current form appear to perpetuate existing barriers.

Responses to the barriers

Individuals, agencies and the government have struggled with these dilemmas and I want to give three examples of positive practice that have been used to try and overcome the barriers I have described.

I am going to describe three examples:

- Crossing Bridges – Training resources for working with mentally ill parents and their children
- Local interagency protocols
- The Family Welfare Association Building Bridges Projects

There are other examples including: the recruitment of specialist posts by mental health trusts and local authorities to encourage and facilitate 'working together'.

1. Crossing Bridges -Training Resources

Providing training for staff has been one of the most frequently used examples of helping staff understand other specialist areas as well as facilitating collaborative working across specialisms.

Crossing Bridges is a pack of training resources for working with mentally ill parents and their children. It was commissioned by the Department of Health (DOH) and was published in 1998.

The resources are designed to promote good practice amongst staff in adult mental health and children's services, as well as within primary care and the voluntary sector. The aims of the resources are to:

- Raise awareness and promote better understanding and skills in staff working in both adult mental health and child welfare services
- Encourage more effective collaboration for the benefit of mentally ill parents and their children

-
- Encourage analysis of the local context and how organisational systems can work together to develop better co-ordinated service provision to meet the needs of all family members.

Crossing Bridges was intended to be implemented nationally. The biggest weakness in the development of the Crossing Bridges national programme has been the absence of a centrally co-ordinated implementation and evaluation strategy.

On publication copies of the training pack were sent to every local authority in England. And this was unfortunately the sum total of the dissemination and implementation process. There was no launch, no publicity, no following up to evaluate use and impact.

SCIE have published a research and development project called ***Alcohol, Drug and Mental Health Problems: Working with Families*** – Kearney, P., Levin, E., Rosen, G. During the SCIE research and practice review for '***Working with Families***' they asked local authorities about the use of the Crossing Bridges training pack. And the majority of respondents were not familiar with Crossing Bridges despite every one of them being sent a training pack. Some said it was on the director's shelf.

Therefore despite the investment made by the DOH, there is little in the way of formal evaluation of the extent of uptake, usage of the materials, changes in practice and service developments, or impact on service users as a consequence of training.

2. Interagency Protocols

Alongside training programmes the other most common local response has been the development and introduction of local interagency protocols in some but not all agencies.

In many agencies protocols and training have been introduced together to compliment each other. A protocol is the message that the organisation gives to its practitioners about:

- What to do
- Why to do it (that is, the organisation's values and policy statements)
- How to do it (that is, its practice guidance and implementation processes).

It is the recording of an agreed way of acting, to achieve an agreed purpose. Therefore, how the agreement comes about, and who is involved in making it, are essential prerequisites to successful working.

People involved in the development of protocols say that an enormous amount of work and time is involved in producing them, getting them agreed, and in particular getting them owned and used within and across health and social care agencies and teams.

I have been involved in training sessions helping to introduce protocols and have gone back to do more training 6 months and then a year later and very few new staff knew a protocol existed and even less were using it.

Protocols are useful particularly when they are part of wider strategic change but in my experience the potential weakness in protocol development is very similar to Crossing Bridges. If the necessary building blocks including plans for dissemination, implementation and evaluation are not put into place then it is unlikely there will be time to carry them out and there will be no way of telling just how effective the protocol could be.

Despite the problems I have described there are some very good examples around. Protocols are local documents and if they have been produced locally there can be more

ownership and therefore commitment to change. And even without an overall evaluation on impact it is probably safe to say that it is better to have a protocol than not.

If you are thinking about developing a protocol or reviewing your own then SCIE have published '**Families that have alcohol and mental health problems: A template for partnership working**'. This guide:

- Offers a template or model for producing inter-agency protocols
- Identifies the main features of a good protocol and offers advice on getting started on the process.
- Has a section on policy legislation and procedures

3. The Family Welfare Association Building Bridges Project

This third example is a good example of collaboration between the voluntary sector, the local authority, health and local service user groups. It is also an example of how practitioners on the front line can be instrumental in practice and service change.

The Lewisham Building Bridges Project, run by the Family Welfare Association in partnership with the Lewisham Social Services, the South London and Maudsley Mental Health NHS Trust and the Lewisham User Forum, opened in 1998.

The idea for the project came from social workers in the London Borough of Lewisham who were struggling to work across specialist services to meet the needs of families locally.

Services that have been provided by the Building Bridges Project are:

- **Individual Casework:** counselling with adults, therapeutic work with children, advocacy, practical assistance explaining parental mental illness, benefit work etc.
- **Group Work:** groups provided include a group for mothers and children, a summer activity programme with separate activities for teenagers, an after school club, a domestic violence group, drop in groups and parenting programmes
- A new group starting this month is a group for women whose children have been adopted.
- **Training and Sharing Good Practice:** training and seminars have been provided for foster carers, social services and health staff
- **Home support service:** This is called Family Link and it offers an intensive home-support service to engage family members in developing strategies to improve their day to day lives

The opportunity to respond to wishes as well as needs (which are usually defined by others) has been made possible here by the collaboration of voluntary, user and statutory agencies enabling work to take place with service users across the continuum of need. And not just with those service users who meet the referral criteria for child care and CMHT teams.

The primary difficulty that the Building Bridges Project has continued to face is in securing ongoing funding which has made it difficult to plan ahead and has caused interruptions in the development and expansion of the project over time. Securing continuous funding is difficult for many voluntary sector agencies however in this situation the difficulties are magnified. A project that straddles both adult and child care services does not fit with the policy drivers that influence the funding criteria for either specialist area. This makes it difficult to compete with more 'obvious' (for want of a better word) funding applications that fit neatly into adult or child service provision.

The services that this project provides have been fully evaluated with very positive feedback from parents, children and other family members and also adult mental health and child care staff who are the main sources of referral.

The Family Welfare Association has been able to build on the success of this project and there are now five Building Bridges Projects running across the country.

Parental mental illness and child welfare: an interagency professional network

To finish off I want to summarise where I think we are now and leave you with details of a new project that is starting at SCIE.

There is much to celebrate in this area of work but there is still a lot more room for development. What we have is a clear idea from research and from parents and children about what is needed and the standards they expect. What we do not have, is a clear idea nationally about how we are doing as organisations and workers and what else needs to be done.

I have given some examples of how the government and local agencies have tried to bridge the gap between specialist services. However, more evaluation of how these examples impact on practice and ultimately families is needed if we are to build on these in future developments.

SCIE is beginning a new project. It is starting a **National Interagency Professional Network** for those people working with parents with mental illness and their children from social care and health. It doesn't have a name yet and if anyone has any ideas I would be pleased to hear them. It is hoped that among the other network objectives that the network can help in this process of evaluating what is happening locally and nationally.

SCIE plans to launch the network with a conference in July 2004. Practitioners and managers from health and social care from both child care and adult mental health services will be invited along with service users and their carers. There are already national networks in Australia and in Europe as they share some of the difficulties that we have in the UK. We hope to learn from them. The network's ultimate aim is in raising practice standards by improving knowledge, sharing information, and bringing about policy change.

If people here are interested in being invited to the conference or finding out more then you can contact me with your details.

Marie Diggins can be contacted at SCIE, tel. 020 7089 6840,
email marie.diggins@scie.org.uk

The Afternoon Discussion Groups

In the afternoon the participants chose membership of groups according to particular issues. The foci of the groups were:

- a) The needs of young people moving into adult mental health services.
- b) Young people in secure accommodation with mental health needs.
- c) The mental health needs of children and young people affected by crime
- d) The needs of children, young people and parents where there are parental mental health problems.
- e) The needs of children and young people from black and ethnic minorities.

These notes are compiled from the flip charts completed by the groups to record the solutions that they suggested. The amount of information provided on the flip charts varied considerably. A full account is only available for group (c).

The needs of young people moving into adult mental health services

Communication

- More communication needed between CAMHS and Adult Mental Health Services.
- Better liaison and closer work between different agencies, for example, housing, Primary Care Trusts.
- There needs to be a decision making group with clear objectives
- The allocated worker should have a liaison role.
- Transitions between services need to be improved.

Flexibility

- There should be fuzzy or flexible borders between services.
- We should get rid of 16 – 18 age gap.
- Need to clarify age restrictions on entry to services.

Service users

- Carers/users should be central to discussions and should be involved in decision making.
- Publicity is needed to make people aware that specific services exist. The profile of the services available needs to be raised.
- Service users and carers need knowledge because that gives power. Would a web site be useful?
- There is a need for access to supported housing.

Workers

- Joint Training/ is needed to lead to joint working
- Consistency between workers and between services
- Need to develop the role of Link worker/Gateway worker.

Young people in secure accommodation with mental health needs

The relevant legislation for this group of young people is the Children Act 1989, the Mental Health Act 1983. Some of the young people come through the criminal route, but not all. Secure accommodation is used to manage the behaviour of young people with 'risk taking' and self-harming behaviour, and it needs forward planning. These young people will not necessarily engage with CAMHS, and need more responsive services, which may risk being intrusive. The lack of engagement of these young people with community based services

may result in their being excluded from getting help. They may benefit more from the therapeutic interventions that are possible in secure accommodation.

However, a very high level of risk needs to be present to get access to secure accommodation. There are problems over dual diagnosis, and the 'right' diagnosis may be needed to get access. Risk assessment is important, but it is not clear how far services reduce the level of risk.

Solutions

- The multi-disciplinary Youth Offending Teams (YOTs) offer one model.
- Assertive outreach teams can be successful.
- Families need practical support. Children's Trusts may make it easier to provide a 'joined up' response, and better information sharing with Education.
- The post for a community psychiatric nurse in the Youth Offending Service was seen as positive.

CAMHS covers mental illness, behavioural and emotional problems, Adult Mental Health services do not, so there are problems at the transition.

The mental health needs of children and young people affected by crime

We started by discussing a case study raised in the presentation about a young victim of sexual assault who experienced difficulty in accessing appropriate support and mental health services.

We discussed how normally a multi-agency child protection committee would produce a child protection plan, which would outline the identified needs of the child and any therapeutic service required. However, we acknowledged that sometimes people 'fall through the gaps' – as in this situation where the girl didn't feel able to access sufficiently independent support. Situations may change and develop and the child's thoughts and feelings may change – so services need to be flexible enough to pick up mental health issues even after direct child protection issues have been resolved. A child may no longer be 'at risk' but that does not mean that they do not require a 'therapeutic service'.

We went on to think about **how** individual children and young people can actually come forward and access mental health services – **who** would they go to?

Social services and GPs. It was felt that generally children have a negative perception of social services – and so would not approach them directly. We attributed this to their perceived status and image. We also acknowledged the difficulty of accessing services through GPs. It was felt that GPs can be reluctant to attach the stigmatising label – 'mental health problems' to a child because of the belief that this may cause them problems in later life.

The idea was floated that young people might find it easier to place their trust in voluntary organisations, because they are not part of the 'establishment'. Where a counselling service is at the disposal of the voluntary sector, this can be accessed in ways that are more imaginative than is conventional.

CAMHS open-access policy. We discussed the advantages and disadvantages of an open access policy to CAMHS. One example was cited where CAMHS had run an open access policy, there had not been a great take-up rate, and it had been discontinued. This had been discontinued because of questions about which budget should cover the service.

Pre-trial therapy. It was felt that there was still a lack of clarity around the Crown Prosecution Service policy on therapies before trial. There was a sense that this confusion prevented children being referred for counselling.

Counselling in GP surgeries. Where GP surgeries have counsellors, these can be underused; this was thought to be because greater value can be attached to treatment by or under the supervision of doctors.

Drop-ins. Concern was raised that these can be underused. Devising innovative ways of access may increase the take-up rate.

Bullying. It was felt that current approaches to victims of bullying risk stigmatising the victim. Interventions intended to sustain the good mental health of children who are bullied should be based on an acknowledgement that their reaction is a normal reaction to a distressing event and not a result of their own inherent behaviour and mental health. It was felt that it was a shame that the young people who commit bullying rarely access or are referred to mental health services. Effective methods of tackling bullying should address the mental health of the bully as well as the victim.

Anti-bullying units and policies within schools. Whilst the majority of schools have policies on bullying, budgets to tackle the problem have not been devolved. This means that schools are reluctant to refer children where there may be a cost implication. The school's image is also a barrier. Schools need to sell themselves and appear successful; if a school admits it has a bullying problem this can be detrimental to their public image. Many schools state that they do not have a problem with bullying and there was concern in the group that some schools might not be acknowledging they have a problem.

The needs of parents and children where there are parental mental health problems

The discussion focused on problems of communication, which could take many different forms. Failures in communication manifested themselves through:

- Failure of workers with children to value the knowledge of the family held by mental health workers.
- Failures to pass on information; although there were protocols for passing on information, there was no duty to do so.
- Problems around the differing 'time-schemes' of children and adults; the time allowed and the pace of work with an adult service user might not provide change quickly enough to meet the needs of a child.
- Too many workers being involved.
- Lack of continuity; the Children and Families teams of the SSD worked to a shorter term than the mental health teams.

There were a number of factors behind the communication problems:

- For social workers, specialisation comes very early in their career. Relatively few workers change their field of work after their first post. As a result, there is a lack of shared experience between those working in adult mental health and those working with children. They did not have the same experience of service history, policy and procedures.
- Structures and working practice are policy and management driven. The enthusiasm is there on the ground to make things work, but it doesn't connect.
- Low staffing levels lead to short term work.
- There are not sufficiently clear and explicit plans, which are needed when many workers are involved in the same family.

-
- Shortage of professional time limits the time that can be spent on establishing good relationships with other professionals.
 - Management does not value time spent on informal inter-agency and inter-professional contacts, such as lunch time meetings or discussion groups.

There were positive suggestions for ways forward:

- Building a shared commitment to a community, so that professionals do not feel that they are working in isolation.
- Being pro-active in communication.
- Providing joint training for professionals with children and in adult mental health.
- Family group conferences provide a good model for joint and co-operative working.
- Using joint assessment as a means to broaden the understanding of workers in both adult and children's services.
- Using staff personal development plans to develop skills in working with other service users and services.
- Taking all opportunities to develop informal contacts with other agencies.

The most important need was for more training across professional boundaries, and for shared inter-agency training.

The needs of children and young people from black and ethnic minorities.

There are advantages and opportunities in the current changes that need to be identified and evaluated.

Ways forward

- There have been constructive changes in practice that build in user involvement and consultation. These should be promoted.
- There should be training for all, across the different professions, using a holistic approach.
- Support needs to be put in early, for example in schools through providing black mentors for black young people.
- Local implementation teams provide a way for people to link in to what is happening, but there needs to be a way for CAHMS to connect to these. Teams need to hear presentations from users and carers.

There is a need to

- Acknowledge the diversity within the black and ethnic minority communities.
- Acknowledge the needs of young people with dual heritage
- Feel able to check things out and be open to feedback, (e.g in language). It's OK not always to know.

It would be useful have a way of learning about the good practice initiatives that are already going on around the country for pro-active work with ethnic minority communities.

Summary and conclusions

The wide ranging nature of the discussions – from policy to practice - reflects the mixture of participants. The presenters and the discussion groups identified many of the same problems and anxieties.

The problems identified both by the presenters and the groups were:

- Lack of certain specific services
- Shortages of resources leading to long waiting lists and restricting availability of treatment
- Shortages of resources leading to inappropriate placements or placements far from home and family
- Shortages of professional time leading to crisis-only responses, short term work, lack of preventive work, failures of communication, unwillingness to take cases
- The lack of a shared knowledge base of mental health for all workers with children
- The undervaluation of the voluntary sector
- Budgetary and institutional barriers between agencies and services leading to failures in effective planning and to a less effective use of resources.

The problems identified by the presenters, but less consistently identified by the groups (possibly reflecting the lack of service user participants)

- Failures to consult young people and their families
- Failure to include young people in planning their care
- Failures to communicate with young people about short term and long term plans

Ways forward

Some of the suggestions were for action that needed to take place at management and policy making levels; such as the co-ordination of commissioning. Some were at the level that could be promoted or put into practice by front line workers and their managers:

- Secondment of staff between agencies
- The development of link workers
- Making time for informal contacts with workers in other agencies
- Developing strategies for shared assessments
- Joint training
- Greater involvement with carers
- More attention to the views of young people.

Conclusions

There was general agreement about the nature of the difficulties experienced by service users and professionals. It was also agreed that most of these were ultimately caused by a lack of resources.

A further source of problems, partly but not entirely a resource issue, was the inflexibility of the system, the dominance of targets and rigid agency or budgetary boundaries. A flexible response to the needs of the children and young people was frequently frustrated by resource allocation based on categories (whether diagnostic categories or age/education categories) rather than need.

The discussion groups recurred frequently to training needs. They wanted a more generic approach to training, which would take into account the need for knowledge outside one's own specialism. This points to a need for changes to the curriculum of pre-qualifying training. They also wanted joint inter-agency and inter-disciplinary training at post-qualifying

level. It was frequently the case that workers could not take advantage of even those training opportunities that were available because they lacked time.

Professional time was the most important resource that the participants lacked. The participants felt that they were unable to undertake the work that they saw needed to be done, because they could not spend enough time with service users and carers. Neither did they have the time to co-operate and communicate effectively with other professionals. Time was an essential tool in their work. They needed time to be able to build the relationships, with service users, with carers and with other professionals, on which an effective and sensitive service could be based. In a sector that is already understaffed, this has major implications for training and recruitment. In her opening address, Dr Trowell pointed to the problem, that recent government initiatives for the development of CAMHS would require a considerable increase in qualified workers. The discussions of the participants demonstrate how much the services are already suffering from existing shortages.

As has already been indicated, the perspective of the service users – children, young people and parents – was under represented amongst the participants. However Tina Jackson provided some feedback from young people, and Sheena Foster gave a voice to the families. These quotes are from their presentations:

A 14 year old boy talked about the impact of inadequate resources and delayed intervention.

“They (services) should do things before they have to - if I’d had the same kind of help then that I am getting now this wouldn’t have happened. I feel like people care now and they didn’t before.”

Sheena Foster emphasised the importance of listening and building trust. This is true for co-operation between professionals as it is for co-operation between users and professionals.

“We have to be able to trust the services and that’s difficult if we don’t feel our voice is being heard. If we trust the services we respect the people who work in them and are able to be more honest and open. That’s a working partnership”.

These statements summarise the central points made during the study day – the need for adequate resources, and for the time and skills to listen.

Appendices

Appendix A: Programme for Falling Through the Gaps SPN Study day, York, 24 October 2003

Time	Programme	Presenter
9.30	Registration	
10.00	Welcome by the Chair, introducing the Social Perspectives approach	Judy Foster, Chair of SPN
10.10	Introduction: the themes of the study day	Judith Trowell
10.30	The voices of young people: - <ul style="list-style-type: none"> • Input from a carer perspective • 'Not working and not working together': report on a survey with young people in secure accommodation 	Sheena Foster Tina Jackson
11.00	Coffee	
11.30	The role of transitional workers: a joint Warwick University and University of Coventry research project.	Judith Trowell, Di Phimister and Keren Corbett.
11.50	The mental health needs of young victims and witnesses.	Ben Smith
12.05	'Identifying the gaps'. Discussion groups	Groups of 12 - 14 with questions to structure feedback.
12.45	Feedback from the groups	Chair and facilitator
1.00	Lunch	
2.00	Families and parental mental illness: examples of positive practice	Marie Diggins
2.20	'Looking for solutions'. Five discussion groups each with a different focus.	The foci of the discussion groups will be: <ul style="list-style-type: none"> f) the needs of young people moving into adult mental health services. g) young people in secure accommodation with mental health needs. h) needs and services for children who are victims of crime. i) the needs of parents and children where there are parental mental health problems. j) the needs of children and young people from black and ethnic minorities.
3.00	Tea	
3.30	Feedback	Chair and facilitator
3.45	Plenary and reflections	Panel: presenters and chair
4.00	Close	

Appendix B

Biographies of the presenters

Judy Foster

Co-Chair, Social Perspectives Network

Judy has always been concerned with the emotional and mental well being of children and families as a social worker, manager and trainer. Latterly she has been developing national occupational standards and training programmes for carers and support workers.

Judith Trowell

Professor of Child and Family Mental Health

Judith Trowell is Consultant Adolescent and Child Psychiatrist at the Tavistock Institute, London. She is also Director of CAMHS Learning and Development Centre, West Midlands, Regional Fellow of West Midlands National Institute for Mental Health in England and Professor of Family and Child Mental Health in the West Midlands.

Judith and her team – Di Phimister and Keren Corbett, put in a successful bid to carry out a study on 'Improving services for the transition from child to adult mental health' The two-centre study is being conducted in Coventry and Solihull; a base line assessment of the existing services was conducted via interview and questionnaire prior to the appointment of transition workers and then again after a year in post. In the interim, regular discussions with workers and service users have taken place to assess the 'work-in-progress'.

Sheena Foster

Carer

Sheena Foster is Vice Chair of the Northern Region Committee of Rethink and was originally involved in the 'Listening to Parents' Consultation', which led to 'Bright Futures'. Since then she has been giving presentations, seminars and workshops, the most recent of which was 'Working with families; giving people their lives back'.

She is particularly interested in recovery and how carers can support their relative's journey and she also had an article published in 'Mental Health Practice' entitled 'Recovery in Families'.

Currently she is involved in Local Planning and Implementation. She is a member of the Social Inclusion Steering Group at the NCMH and also sits on the Board. She is also on the regional Committee of TOPSS.

Tina Jackson

Development Officer

Tina Jackson is currently working as a multi-agency CAMHS Development Officer in Teesside on secondment from Middlesbrough Social Services Department.

Her background is in social care, having worked in child care/child protection followed by five years as an approved social worker on an adolescent Tier 4 in-patient unit. She returned to Social Services in 1997 as team manager and was responsible for the development of an out of hours community support service. In 2001, she was seconded to her current position within CAMHS.

The post (funded through the national CAMHS Grant allocation) was principally concerned with supporting the Tees community in developing and implementing a CAMHS multi-agency strategy. However, it was agreed that part of the time should be used to undertake broader

development work across the former Northern and Yorkshire Region, on behalf of Social services Inspectorate and the Northern and Yorkshire Regional Office.

In 2002 it was agreed that the post would be extended for a further year with the 'regional' time being used to complete this study. The regional element of the post ends with the completion of this work. Tina is to continue working part-time in Tees on further multi-agency developments while utilising the other days by undertaking independent CAMHS project work.

Keren Corbett, RMN, MA, MSc.

CAMHS Regional Development Worker, West Midlands NIMHE

Keren has worked in a variety of mental health services. Her background is in mental health nursing, counselling and psychotherapy and she has held a variety of senior positions in clinical services, Health Authorities and the West Midlands Mental Health Development Team. Her new role as RDW for West Midlands within the National CAMHS Support Service focuses on supporting CAMHS in developing comprehensive services. Key achievements within NIMHE West Midlands for CAMHS included establishing networks and a Learning and Development Centre, leading Tier 4 review and strategy development, establishing transition pilot projects and supporting the establishment of specialized commissioning arrangements.

Di Phimister⁷

Senior lecturer, University of Coventry

Di is currently a senior lecturer at Coventry University with the nursing and midwifery team and also has additional responsibility as the course tutor for the pre-reg branch programme. She also attempts to maintain her clinical skills and grasp on the real world by spending a day a week with a generic community mental health team. She has a specific interest in suicide and also the use of self-injuries behaviors. Previous experience as a lecturer practitioner in A&E highlighted the difficulties for young people and anomalies in service provision, which inspired her to become involved with this project. She is currently also conducting research as part of her MA into suicide rates in students and the support the academic institutions provide.

Ben Smith

Policy Officer, Victim Support

Ben joined Victim Support's Witness Service as a volunteer in 2000, and became the Deputy Coordinator of Southwark Crown Court Witness Service in 2001. As a member of the service he provided practical and emotional support to victims and witnesses of crime, including children and young people. Last year Ben moved to Victim Support's policy department where he is part of a team seeking to raise awareness of victims' and witnesses' needs in both the criminal justice sphere, and also in social policy areas (eg health, housing and finance). In particular, Victim Support aims to raise awareness of the mental health needs of children and young people affected by crime.

Marie Diggins

Project Manager, SCIE

Marie Diggins began her social work career as a generic social worker and then as an Approved Social Worker and manager in a London CMHT. She now works as a project manager at the Social Care Institute for Excellence (SCIE). Marie is a co-author of *Crossing Bridges: training resources for working with mentally ill parents and their children* (DoH 1998). She carried out research in the London Borough of Lewisham on the interface between adult mental health and child care services and building on this work helped her develop local resources for parents with mental health problems and their children.

⁷ Di Phemister was unable to join Keren in presenting their research owing to a bereavement.

Appendix C

Handouts and references for Marie Diggins' presentation

A. Service user perspectives

For **themselves**, parents want:

- more understanding and less stigma and discrimination in relation to mental illness
- support in looking after their children
- practical support and services
- good quality services to meet the needs of their children
- parent support groups
- child-centred provision for children to visit them in hospital
- ongoing support from services beyond periods of crisis
- continuity in keyworker support
- freedom from fear that children will inevitably be removed from them.

For their **children**, parents want:

- opportunities for children to talk about any fears, confusion and guilt
- opportunities for children to meet adults they can trust, and to participate in activities where they can meet other children
- provision of explanation and discussion about the events and circumstances surrounding the parental illness
- continuity of care and minimal disruption of routines during crises (including hospitalisation of parent/carer)

Children and young people want:

- age-appropriate information about the illness and prognosis
- someone to talk to- not necessarily formal counselling
- a chance to make and see friends.

Children and young people taking on a caring role want:

- practical and domestic help
- recognition of their role in the family
- a contact person in the event of a crisis regarding a parent
(*Reader: Chapter One, page 17 and Chapter Five.*)

A better understanding of how children experience growing up with a mentally ill parent, and the impact on them of this experience, helps service planners and professionals to improve the effectiveness of interventions.

Successful interventions, both in the short term (to reduce stress and negative impacts on children) and longer-term preventative strategies, can potentially reduce the proportion of children who go on to require psychiatric services as adults.

B. Working together

Organisational issues

Barriers to effective, collaborative intervention include:

- separate legislative frameworks
- separate service delivery
- increasing specialisation within service provision
- contracted-out service provision
- separate planning frameworks for adults and children in both social services and health services
- financial pressures leading to reduction in existing collaborative services
- inflexible resource allocation
- a climate or culture of crisis or blame

Operational issues

Barriers to effective, collaborative intervention include:

- different priorities for adult and child services
- lack of joint structures and procedures
- concerns about confidentiality
- lack of knowledge of the 'other' system and/or skills to assess the needs of the other family members
- lack of understanding of each service's priorities.

(Reader: Chapter Four)

Assessments

Poor collaboration can lead to:

- uncoordinated assessments, planning and interventions
- assessments not informing each other
- narrow, separate perspectives on the needs of the mentally ill parent and child
- the significance of factors such as domestic violence or drug and alcohol abuse on both the ill parent and the child being missed or underestimated
- limited understandings of race, culture and power relations .information not being shared appropriately
- workers not sharing each other's expertise and knowledge.

(Reader: Chapters Six and Seven)

Access to services

Poor collaboration can lead to:

- thresholds being used to keep clients out, not to target services to prevent future need for intervention.
- parents and children receiving no services until there is a mental health or a child protection crisis.
- intervention in black families being more likely to be draconian/coercive
- intervention being avoided, as it is seen as the responsibility of the other specialist area families being inundated with workers from a bewildering range of agencies
- resources not being used collaboratively and creatively to support individuals and the family as a whole.

(Reader: Chapters Six and Four)

C. Key messages from 'Crossing Bridges'

Key messages for agencies:

- common policies and agreed protocols are needed
 - the needs of children and parents must be considered jointly
 - agency priorities need to be reviewed in relation to joint client needs
 - service -planning needs to be co-ordinated and integrated
 - there is a need for a flexible range of services (long and short term) to support mentally ill parents and their children
 - changes in practice need to be within a framework of agency change
 - training strategies need to be planned within and across agencies
- (*Reader: Chapter Four, page 115; Chapter One, pages 19-21.*)

Key messages for practitioners:

The parent's capacity to parent can be promoted by:

- actively and assertively treating mental illness
- providing early treatment (effective access and outreach)
- promoting insight into illness and its implications
- providing information about diagnosis, prognosis, services
- reducing severity and duration of episodes .preventing relapse
- encouraging or ensuring compliance with appropriate treatment, exploring reasons for non- compliance
- working with the well parent and extended family
- ensuring intervention in black families is culturally appropriate and is not an under- or over- reaction
- helping the ill parent, other family members, and the child if appropriate, to plan for crises providing practical support (housing, benefits, childcare) to reduce stressors
- identifying and reducing the impact of other stressors (domestic violence, racism)
- identifying key points for intervention (for example, the first 24 hours after admission to hospital).

(*Reader: Chapter Two, final section; Chapters Seven and Eight*)

Children's welfare can be promoted by:

- identifying where the child's needs are not being met, including the need for safety intervening to meet the child's needs and to protect the child
- reducing exposure to parental discord, and hostility and promoting the expression of age-appropriate praise and warmth
- promoting positive parenting
 - reducing changes of carer
 - promoting continuity of care
 - promoting appropriate contact
 - providing practical support for parenting
 - developing parents' understanding of children's needs
- identifying and meeting needs arising from separation and loss
- helping parents to understand the illness (symptoms, treatment, ways of coping), its impact on their parenting and the impact on the child
- agreeing with the parent what the child will be told about the illness
- helping children to:
 - understand the illness
 - recognise changes in the parent and their relationship when symptoms recur

-
- know they are not the cause of the parent's illness
 - respond to questions from friends
 - promoting open discussion about mental illness in the family where children can ask questions and parents can respond positively
 - encouraging and maintaining other positive and supportive relationships, including positive relationships and experiences at school
 - providing practical support to reduce stressors
 - identifying and reducing the impact of other stressors (domestic violence, racism) identifying and addressing the impact of any caring role taken on by the child.

(Reader: Chapters Seven and Eight)

Summary

- Know who is in the family, and see the family as a whole.
- Ensure the impact of parenting on the ill adult is assessed, and the impact of the illness on the parent's capacity to parent.
- Ensure the child's needs and the impact of the illness on the child are assessed
- Consult, collaborate, work together.
- Inform each other's interventions.
- Negotiate to share appropriate information to improve the network of support.
- Promote communication between practitioners and family members and between parents and children.
- Be imaginative and innovative in the use of resources.
- Build bridges between specialist areas, and cross them!

(Reader: Chapters Seven and Eight)

D. Barriers to working together

Priorities

It's a good idea but...not in the real world we work in.

Relationships

We want to work in partnership but *they* won't.

Change is too difficult in our beleaguered organisations.

There will always be conflicts of interest.

Resources

It all comes down to whose budget the money will come out of.

It's a good idea, but we're already overworked.

There's too much demand on our services now, without identifying new client groups.

It's my job to protect my resources and shift what work I can elsewhere.

Joint work is expensive because it always means two people going on visits.

Planning

There's either too many people involved in working with a family or too few.

Everything depends on how well individuals get on and work together, not on the system.

Our managers don't provide an overall agreed framework.

Attitudes

We know all this, nothing changes, it was no better when we worked generically.

We can't say what we think. There's enough bad feeling between us as it is.

It's not my responsibility.

I feel very anxious about this area of work.

Professional boundaries

My workers are perfectly capable of doing this work alone.

We are specialist workers. It's not our job to know about other areas of work.

They have no idea what we do.

I can't be responsible for other areas of the service.

We don't need training to tell us what the problems are.

Knowledge

If qualifying training was adequate, workers would have the relevant skills.

I don't have the skills to talk to or assess children/mentally ill adults.

I know very little about the other specialist area, but don't feel I can say this.

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Marie Diggins, October 2003

Appendix D

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About SPN

The Social Perspectives Network is an independent organisation which is open to anyone interested in looking at mental distress in terms of people's social experience – how social factors may both contribute to people becoming distressed, and play a crucial part in promoting people's recovery. Social Perspectives Network is open to practitioners of all disciplines, service users / survivors, carers, policy makers, academics, educators, service managers and others who may be interested in these issues.

SPN seeks to be inclusive. There is no assumption that there is one single social model, or that one social perspective is more valid than another. Instead different perspectives may all be seen as pieces of a 'jigsaw' that may gradually come together. SPN seeks to operate in a non-hierarchical way, so that everyone's experience, knowledge and skills are valued.

SPN receives funding and support from the National Institute for Mental Health in England (NIMHE) and the Social Care Institute for Excellence (SCIE).

SPN has a central base in London at the Social Care Institute for Excellence. From here, national initiatives are co-ordinated which focus on areas such as research, policy development, or more specialist areas of interest such as child and adolescent mental health. Alongside this, in order to influence policy and practice locally, SPN has local networks in nine English regions, working closely with each of the NIMHE Regional Development Centres.

SPN aims to:

- Develop and pull together the knowledge base – what we already know, or may need to research, concerning mental distress from a social perspective, what works in terms of service responses, self-help strategies, etc
- Support practitioners, users and carers in putting social perspectives into practice
- Influence the development of mental health policy from a social perspective

SPN has four main functions:

- It brings together service users, carers, practitioners, educators, policy makers and researchers to share experience, knowledge, ideas and perspectives
- It promotes the development of new ways of thinking (social models) and their application into policy and practice.
- It collates, publishes and disseminates knowledge, experience, research and practice guidance, so that it is accessible to all.
- It facilitates regional and national discussion on mental health issues so that collective views may be presented to policy makers, service commissioners and providers.

If you want more information or would like to become actively involved in any aspect of our work, please refer to our website or email the SPN national administrator who can put you on SPN mailing lists and give you contact details for your regional co-ordinator.

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