

Mental Health and the Family: New Developments

Notes from a study day

Parental Mental Health and Child Welfare Network

Paper 3



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Foreword

The scale of ambition in the range of new projects being funded by the government is impressive. The message 'Think Family' has struck home at least in the pilots reported here. In planning the day the Network felt that there were so many new initiatives that it would be worthwhile to take stock of what was being done in the area of Mental Health and The Family.

The forthcoming SCIE/NICE guidelines will give a huge impetus to work in this area. They will show the limited evidence base in this area. To hear of two large scale randomised control trials of the Family Nurse Partnership pilots and the Multi systemic Therapy Pilots was good news given the scale of resources involved in trials of this kind.

But it was not all good news. Even when a smaller scale project has been evaluated and shown to be of benefit like the CAPE project in Greenwich it is a hard road to find continuation funding. That road is going to get harder as funding is squeezed in the wake of the economic crisis. The other danger is that good interventions are extended prematurely. For me at least the extension of Family Intervention Projects which have been successful to Child Poverty and Crime Prevention FIPs sounded like mission creep with a danger of diluting the sharp focus of the original projects.

The study day was a reaffirmation of the Network's ability to draw together service users, practitioners and researchers with a shared objective of improving the quality of services. The material assembled here is both a reminder of a very positive and enjoyable day but also will help a wider audience appreciate the range of initiatives taking place.

Terry Bamford
Director
Social Perspectives Network

Chair's opening remarks

Nicky Stanley, Professor of Social Work UCLAN

Notes: Vicky Nicholls

Nicky Stanley introduced herself as somebody who writes and researches in the area of family and child welfare. This event offers a chance to catch up on the raft of initiatives that impact on the work of the Parental Mental Health and Child Welfare Network.

We are one week into the implementation of the Mental Health Act and we can explore the new role of Approved Mental Health Practitioners (AMHPs) and how it relates to the work of the Network. SPN is working to ensure work with children and families is integrated into this role. It is a priority to see that work with families is integrated into mental health work as a whole. We hope that today will assist you in your own roles and thinking about families.

The impact of the nine key changes on families

Claire Barcham, National Coordinator of the AMHP Leads Network

Notes: Vicky Nicholls

Claire explained that the 1983 Mental Health Act is still the key legislation. The changes coming into force are amendments to this Act. Guiding principles are included, and people have worked hard to ensure that families are considered.

Claire ran through the nine key changes. The Deprivation of Liberty safeguards don't come into force until 2009.

Change 1: Changes to the definition of mental disorder mean that the decision now is much more about is it appropriate to assess, or care for the person in hospital, whatever their age.

Change 2: criteria for use of compulsion. Within these (section 3) Claire highlighted that para 6.11 has a list of considerations that includes the person's role in their family. She gave an example from perinatal mental health – of a woman experiencing puerperal psychosis who needs intervention for the safety of mum and baby. If decision is that a mother and baby unit is needed and nothing is available this same night, then the decision needs to be reviewed when a place becomes available, in for example two week's time, to decide whether treatment is still appropriate and if such a place would help.

The guiding principles give more power to the person to plan for their own future e.g. in relation to their child or children

Change 3: age appropriate services are due to be introduced by 2010, under which hospital must ensure patients under 18 are admitted in an environment suitable for their age. PCTs must now identify hospitals that can receive young people in situations of special urgency.

Change 4: Professional roles – Approved Mental Health Professionals (AMHPs) and Approved Clinicians (ACs) – widens pool of professionals who can become AMHPs (from solely social workers) all of whom undertake approved training. Local training not in place yet everywhere. Interest from CAMHS colleagues as supervised community treatment might enable a young person to get home sooner. AMHPs must demonstrate ability to work within a social perspective, have knowledge of the Childrens Act and keep this up to date. What is the relationship with the employing authority if AMHP not actually employed by social services authority. Who covers legal indemnity?

Change 5: nearest relative – gives person the right to apply themselves for an order displacing the nearest relative e.g. if a young person doesn't want parent to be nearest relative.

Change 6: independent mental health advocate – expected to be in place in April 2009 – to help people understand their rights.

Change 7: ECT

Change 8: supervised community treatment (SCT).

Change 9: mental health review tribunals.

Claire talked through the remaining key changes and congratulated those who had worked so hard to ensure the needs of families were included.

Notes from PowerPoint Presentation – Claire Barcham

The impact of the 9 key changes on families

Mental Health Act 1983

As amended by the Mental Health Act 2007

The key changes to the 1983 Act are:

1. *Single Definition of Mental Disorder*
2. *Criteria for the use of Compulsion*
3. *Age Appropriate Services*
4. *Professional Groups*
5. *Nearest Relative*
6. *Independent Mental Health Advocacy Service*
7. *Patients and ECT*
8. *Supervised Community Treatment*
9. *Referral to the MHRT*

Other amendments include:-

- The ability to move people between places of safety
- Informal admission of young people
- The ability to convey a person to the place you want them to reside under guardianship
- The introduction of the written agreement of a '2nd professional' when renewing s3
- The deprivation of liberty safeguards are introduced into the Mental Capacity Act 2005

Key Change 1

Definition of Mental Disorder

Mental Disorder

- The Act abolishes the four forms of mental disorder in the 1983 Act.
- It simplifies the existing definition of mental disorder: “Mental disorder” means any disorder or disability of mind.
- It removes three of the exceptions in section 1(3) — immorality, promiscuity and sexual deviancy — leaving in only “dependence on alcohol or drugs”.

Exclusions on the basis of dependence on alcohol or drugs

- (3) “Dependence on alcohol or drugs is not considered to be a disorder or disability of mind for the purposes of subsection (2) above”

But disorders which arise from dependence on alcohol or drugs can be mental disorders (e.g. alcohol induced psychosis)

The new Section 1

1(2) In this Act:

“Mental disorder” any disorder or disability of mind and “mentally disordered” shall be construed accordingly”

Consequences

- The ‘definition’ of mental disorder is simplified by removing the previous references to immorality, promiscuity and sexual deviancy (but the first two make no practical difference)
- This applies to all sections of the act including short-term holding powers e.g. police’s power to detain citizens under section 136.
- The repeal of the four categories of mental disorder potentially extends the group of people who are liable to detention for treatment (rather than assessment), e.g. under section 3
- So there may be disorders at the margins which are covered by these provisions which weren’t before e.g. probably some disorders caused by head injuries in adulthood which don’t fit into any of the categories now.

The Learning Disability Qualification

This applies to longer term forms of compulsion (e.g. treatment based sections and Guardianship)

(4) In subsection (2A) above, “learning disability” means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.

(2A) But a person with learning disability shall not be considered by reason of that disability to be:

- a) Suffering from mental disorder for the purposes of the provisions mentioned in subsection (2b) below; or
- b) Requiring treatment in hospital for mental disorder for the purposes of sections 17E and 50-53 below

Unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.

Key Change 2

Criteria for the use of Compulsion

Section 3

- The four forms of mental disorder have been abolished
- Consequently, a person can be detained under section 3 whether or not they have a disorder which fits into one of those current four categories.

Section 3 criteria

(2) An application for admission for treatment may be made in respect of a patient on the grounds that —

- (a) he is suffering from **mental disorder** of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
- (b) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and
- (c) appropriate medical treatment is available for him.

- The so called “treatability test” is abolished, and replaced by an appropriate medical treatment test, which now applies to all patients.
- Although it is no longer necessary that the treatment is likely to alleviate the patient’s condition, or prevent it from worsening, the purpose of any treatment provided must still be to alleviate, or prevent a worsening of, the disorder, or one or more of its symptoms or manifestations.
- According to the Act, references to appropriate medical treatment are references to medical treatment which is appropriate in the patient’s case, taking into account the nature and degree of their mental disorder and all other circumstances of his case.
- Treatment need not be under medical supervision, or involve a doctor, and may consist only of specialist care or psychological intervention.

The legal status of the Code and the Guiding Principles

Applying the criteria in individual cases

“In performing functions under this Act persons mentioned in subsection (1) (a) or (b) shall have regard to the code.”

This means that when reaching decisions, professionals must follow the advice of the code or justify why they are not able to do so.

Who is the code for?

- for the guidance of **registered medical practitioners, approved clinicians, managers and staff** of hospitals, independent hospitals and care homes and **approved mental health professionals** in relation to the admission of patients to hospitals and registered establishments under this Act and to guardianship and **community patients** under this Act; and
- (b) for the guidance of **registered medical practitioners and members of other professions** in relation to the medical treatment of patients suffering from mental disorder.

The Guiding Principles

- The Code therefore now provides statutory principles that professionals and others must use to inform their decision making
- Unlike professional or personal values, these principles have been debated in parliament and therefore have greater legal status

How do the Act, the Code of Practice and the Guiding Principles fit together?

Quite simply

The Act tells us what to do

The Code explains how to do it

The Guiding Principles help us to apply the Act in individual situations.

The notion is that the principles are a framework of important values that need to be balanced in particular situations. The principles make the practitioner consider the questions, 'Who?', 'How?' and 'Why?'. These questions must be asked by practitioners in connection with evidence-based approaches that may maximise well-being and minimise compulsion at all stages of the process.

Purpose Principle

1.2 Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm.

Least Restriction principle

1.3 People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

Respect principle

1.4 People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes whatever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation principle

1.5 Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

Effectiveness, efficiency and equity principle

1.6 People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

Key Change 3

Age Appropriate Services

- Age Appropriate Services: it requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).
- The managers must consult someone with particular knowledge or experience of cases involving under 18s.
- This is due to be introduced in 2010

What makes accommodation 'suitable?'(1)

- **Physical facilities:** these should be appropriate for children and young people,
- **Educational opportunities:** children and young people should have the same access to educational opportunities as their peers, so far as they are able to do so, taking into account their mental health,

What makes accommodation 'suitable?'(2)

- **Hospital routine:** Think about the need of younger patients for structure in the day and a planned timetable of activities including mealtimes, therapeutic activities, exercise and leisure.
- **Staff with the right training, skills and knowledge**

Other issues to consider (1)

- Is there something about the patient which means you should use an environment which would not normally be deemed suitable?

Other issues to consider (2)

- If no age appropriate environment is available, do the patient's needs justify using other accommodation instead?

A140 Notification of hospitals having arrangements for reception of special cases

- From 3rd November 2008, It shall be the duty of every Primary Care Trust to give notice to every local social services authority for an area wholly or partly comprised within the area of the Primary Care Trust or specifying the hospital or hospitals administered by or otherwise available to the Primary Care Trust or in which arrangements are from time to time in force for the reception, in case of special urgency, of patients requiring treatment for mental disorder
 - (a) for the reception of patients in cases of special urgency;
 - (b) or the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years.

Key Change 4

Professional Groups:

AMHPs and ACs

Approved Mental Health Professional (AMHP)

- This widens the pool of professionals from which applications for the training to become an AMHP can be drawn.
- So in future, nurses, occupational therapists and psychologists will be able to apply to be trained as an AMHP
- All prospective AMHPs must complete an approved training course

Approved Mental Health Professional (AMHP)

- AMHPs will be assessing 'on behalf' of their local social services authority when carrying out their duties as AMHPs
- All AMHPs will have to demonstrate their ability to work within a 'Social Perspective' and be able to maintain their independence before qualifying as an AMHP

Approved Clinicians (AC) and Responsible Clinicians (RC)

- A framework of competencies has been established for professionals who wish to become Approved Clinicians
- The pool of professionals who can be accredited to take on this qualification is no longer restricted to doctors, but now includes appropriately registered nurses, OTs ,psychologist & social worker.

The result.....

- Having broadened the pool of professionals who can apply for accreditation as an AC - once they have qualified as such they can be appointed as a **Responsible Clinician** for a particular patient (this role replaces that of the **RMO**)
- The aim is that patients in future will therefore be able to have the most appropriately skilled AC appointed as their RC

Key Change 5

The Nearest Relative

- The Act amends the list of persons who may be a patient's nearest relative by giving a civil partner equal status to a husband or wife. (Came into force on 1 December 2007)

Changing the Nearest Relative

- Introduces an additional ground for an order displacing the nearest relative, i.e. that the nearest relative is "otherwise unsuitable"

- Gives the patient the right to apply themselves for an order displacing their nearest relative.

Key Change 6

Independent Mental Health Advocate (IMHA)

- Section 130A deals with the development of the IMHA service
- The commissioning arrangements and guidance will be announced soon – specialist arrangements will be suggested to develop age appropriate IMHA services
- It is expected to be in place in April 09

Who is eligible for the IMHA service

- Anyone subject to compulsion, but not those detained on short term 'holding sections' such as s4, s5/2, s5/4, s135 & s136
- All those on s2, s3, guardianship or SCT are eligible
- Informal patients under 18 where ECT is being considered

The role of the IMHA is to help the patient:-

- Understand their rights under the Act
- Understand the rights others (such as their nearest relative) have in relation to them
- Understand which parts of the Act apply to them, and the effects of the Act on them
- Understand any medical treatment they are given or maybe given
- Understand their rights of appeal, plus other rights they have
- The IMHA will help support the patient to understand *and* make use of their rights and the safeguards available to them under the Act.

IMHA

IMHAs will have:

- an unfettered right to meet with patients in private and
- to meet with professionals and
- they will have access to patients records

(In cases where the patient lacks capacity, the record holder must decide whether and what to release, based on the best interest of the patient)

Key Change 7

Electro-Convulsive Therapy

ECT – section 58A & under 18 yrs olds

Except in emergencies

Two 'sources' of authority are always needed when ECT is being considered for someone under 18.

- First, the treatment must be approved by a SOAD
- Second,
 - if the child or young person has competence/capacity, they must consent
 - If the child or young person does not have competence/capacity, there must be another legal authority for giving the treatment

Where a child or young person lacks competence or capacity

- If the child or young person is detained or on SCT, the authority may come from the MHA itself
- Otherwise, you need to look to the common law or the Mental Capacity Act (MCA). So:
 - for patients over 16, treatment in their best interests under the MCA may be possible
 - patients under 16, parental consent might be possible – but the Code suggests it would be more prudent to seek authorisation from the court (unless it's an emergency)

Section 62 – emergency treatment

- Section 62 continues to allow ECT treatment for detained patients in an emergency without consent or second opinion appointed doctor (SOAD) approval
- However, clinicians will be expected to take account of the views expressed by patients with regard to ECT, and any advance decision they have made

Key Change 8

Supervised Community Treatment (SCT)

Introduction

- Supervised Discharge (s25A) provisions are repealed.
- 'Supervised Community Treatment' (SCT) (s17A) is introduced
- The SCT provisions will allow some patients with a mental disorder to live in the community whilst still subject to powers under the 1983 Act.
- Only those patients who have been detained in hospital for treatment will be eligible for SCT.
- Patients on SCT remain under compulsion and are liable to recall to hospital for treatment.

There is no lower age limit

The AMHP role

In order for a patient to be placed on SCT, various criteria need to be met:

- An AMHP must agree that the criteria for SCT are met, and that it is 'appropriate' to use the powers and
- The AMHP must also agree that any additional conditions are 'necessary or appropriate'

The criteria

The RC & AMHP must agree the following criteria are met:-

- a) 'the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment';
- b) 'it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;'
- c) 'subject to his being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his continuing to be detained in a hospital';
- d) '**it is necessary** that the responsible clinician **should be able to exercise the power** under section 17E(1) below **to recall** the patient to hospital';
and
- e) 'appropriate medical treatment is available for him'.

Patients who are on SCT will be required to keep to conditions whilst living in the community.

'Compulsory' Conditions

Every community treatment order (CTO) must specify the following conditions:-

That the patient makes her/himself available for the purposes of being examined in connection with

- (1) the order's extension, and
- (2) the furnishing of a Part 4A certificate (CTO11)

The patient may be recalled to hospital if s/he fails to comply with either of these two conditions.

Other conditions

Other conditions may be imposed as long as they are 'necessary or appropriate', for one or more of the following reasons:

- **ensuring that the patient receives medical treatment** *and/or*
- **preventing risk of harm** to the patient's health or safety *and/or*
- it is **necessary to protect** other people

Effect of an order

- The authority to **detain the patient in hospital** is suspended.
- The authority to **treat people against their will** under Part 4 of the Act is also suspended (Part 4A governs treatment instead)
- The renewal provisions in section 20 do not apply to the patient. SCT is extended under section 20A

Consent & treatment rules

- Detained patients are subject to Part 4
- SCT Patients of all ages in the community are subject to Part 4A instead-except when recalled to hospital.

- They can't be treated against their will if they have capacity to consent – and (except in emergencies) can't be treated forcibly if they lack capacity (unless someone consents on their behalf)

Treatment rules for children

- Parents or those with parental responsibility cannot give consent to treatment for an under 16yr old on SCT

The clinician responsible for the treatment may treat an under 16yr old in the community if...

- The child has competence and agrees
- or**
- They have assessed and established the child does not have competence to make treatment decision
 - The young person does not object, or not so that force is needed to administer the treatment
 - The treatment is provided by or under the direction of an AC who is also in charge of the child's care

For a young person aged 16 or 17yrs...

- The young person has competence and agrees to the treatment
- or**
- The RC has assessed their capacity to make the treatment decision and is satisfied that they do not have capacity
 - They are satisfied that the treatment is in the child's best interest and
 - The child is not objecting to the treatment to the point where force is needed to give that treatment
- Alternatively, the Court of Protection, or a deputy appointed by it, could consent on behalf of a 16 or 17 year old who lacked capacity

Fundamentally...

- It is not possible to treat a competent child or young person in the community if they object to the proposed treatment
- It is not possible to treat a child or young person in the community who lacks competence or capacity if force would be needed to administer the treatment.
- In such circumstances it would be necessary to recall the child or young person to hospital to administer treatment

Treatment certificates and the SOAD role

- After the first month of SCT, a SOAD certificate ("Part 4A certificate) is needed for medication even if the patient has capacity and is consenting to the treatment.
- Where less than 3 months has elapsed since the child or young person was first given medication while detained, the SOAD certificate must be in place by the end of that 3 month period.

Treatment on recall

- On recall the patient will be subject to Part 4 again- but Section 62A makes some exceptions to the normal rules about certificates.
- The CTO11 which the SOAD completes in the community can also be used to authorise treatment on recall.

Power of Recall

- The responsible clinician may recall a patient on SCT to hospital if in her/his opinion:
 - (a) The patient requires medical treatment in hospital for his mental disorder; and
 - (b) There would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled to hospital for that purpose.
- The RC may also recall the patient if he fails to comply with either of the 'compulsory' conditions
 - That he makes himself available for examination for the purpose of an extension report or
 - To see a SOAD to complete a Part 4A certificate.

Revoking the Community Treatment Order

- Where a patient on SCT is recalled, the RC may revoke the community treatment order if he is of the opinion that the section 3 conditions are satisfied
- and an AMHP agrees with that opinion and that it is appropriate to revoke the order.

The effect of revocation is..

- That the managers have the same power to detain the patient under section 6(2) as if s/he had never been discharged;
- And for section 20 renewal purposes the patient is deemed to have been admitted under section 3 (or other equivalent sections) on the day the order is revoked.

Key Change 9

Mental Health Review Tribunals

Changes to Tribunal under 2007 Act (1)

- It introduces an order-making power to enable the Secretary of State to reduce the time before a case has to be referred to the Tribunal by the hospital managers
- It changes the referral period after 6 months to include any time that may have been spent on section 2
- It means that referrals by hospital managers after 3 years must now be made as soon as the 3 years are up, not at the next renewal date
- It extends the annual referral for those under 16 to adolescents who are under 18

Changes to the MHRT

But – under the Tribunals Courts and Enforcement Act 2007

- Mental Health Review Tribunal (MHRT) is to be replaced in England by the new First-tier Tribunal
- Will be a right of appeal on a point of law to the new Upper Tribunal.

Family Intervention Projects and Family Pathfinders

Gill Strachan, Assistant Director, Families Division, DCSF

Notes: Terry Bamford

Gill flew down from Dundee to join the day. She described herself as a delivery person having spent 13 years in Dundee in a family project before moving to DCSF where she had worked for 3 years.

Families were a priority for Government because of the overwhelming evidence of the impact of poor parenting on social and health inequalities. The risk of childhood injury was starkly greater in socially deprived areas with children. Over one third of stillbirths and neonatal deaths were in the most deprived areas. Deprivation had huge economic and social costs when parental influence was the single most important factor on the 5 outcomes in Every Child Matters. Its impact on educational attainment was greater than the quality of the school.

There had been an explosion of parenting programmes. There was evidence that such programmes could have significant long term effects on behaviour but there were still problems of supply and sometimes of quality in these programmes. Currently there was a big push from Downing Street to include fathers in work with families. The Fatherhood Institute had a part to play in promoting awareness of the importance of including fathers.

There were 3 main strands: supporting local authorities, supporting the workforce and increasing the availability and quality of services.

Local authorities had a key role in commissioning parental support and helping to develop a national framework for parenting strategies.

The National Academy for Parenting Practitioners was the vehicle to support the workforce. It had the task of developing a ten year workforce strategy. It also needed to develop the evidence base which currently was much stronger in the USA and Australia than the UK and ensure appropriate training.

Services needed to cover a spectrum of needs with parenting early intervention programmes and parenting experts being available to support where there were early signs of risk, and family pathfinders and family intervention projects offering intensive support to those families with high needs.

The Parenting Early Intervention Pathfinder programme was aimed at parents of 8-13 year olds at risk. 18 pilots had produced excellent results and the scheme was being rolled out to another 24 LAs in 2008/9. The goal was to cover the majority of LAs by 2010 and to link delivery to the roll out of extended schools.

Two parenting practitioners were to be funded in each LA under the Childrens Plan targeting parents with problems.

Early intervention was the key to shifting inter-generational patterns of social exclusion. There was overwhelming evidence of the impact of multiple disadvantage well documented in the Think Family report. 140000 families had children experiencing five or more of :

- no parent in work
- poor quality housing
- no qualifications
- mother with mental health problems
- low income
- one parent with limiting long term illness
- inability to afford food and clothing.

This cast a long shadow for children in educational attainment, likelihood of suspensions or exclusions from school, running away from home, in trouble with the police and lack of physical activity.

The answer was more family focussed services and earlier intervention with children. This was needed across the spectrum of need. There were 15 Family Pathfinder areas which were developing a whole family approach to assessment moving from a Childrens Assessment Framework to a Family Assessment Framework.

Keys to this were early identification of families at risk, whole family assessment, multi agency support plans, improved information sharing, joined up planning and commissioning and integrated working between adult and children's services.

Family Intervention Projects were aimed at intensive support for the most risky families. There were currently 65 Family Intervention Projects (FIPs) working with anti social behaviour. They work with families on agreed programmes of change using accredited parenting programmes. A key worker 'grips' the family building on strengths and coordinating the various interventions. There is a nominated health professional (NHP) to signpost referrals to appropriate health services.

The evaluations of the projects showed very positive results with a reduction in domestic violence, halving of child protection concerns and reduced behavioural problems in school.

A major expansion of FIPs was under way. The 2008 budget had announced 'Child Poverty FIPs' to test the model with intergenerational worklessness and problems other than antisocial behaviour. The Youth Justice Action plan had announced 'Crime Prevention FIPs' with a project in every local authority to focus on offending risk within families. The aim overall was to reach 20000 families by 2012.

Health was a crucial issue. 80% of parents in FIPs had either poor physical or mental health. There were problems of obesity, poor nutrition and ADHD all over represented in these families. The NHP had a key role in ensuring

effective communication and linking in to specialists in teenage pregnancy, school nurses, health visitors, GPs, CAMHS, psychologists and paediatricians.

What was so positive is that policies were being driven by practitioners. Cultural change did not happen overnight but the direction was right, resources were being made available and the potential gains in well being were huge.

Notes from Presentation

Children and health inequalities

- The risk of childhood injury is associated with the income level in the residential area and the parents' educational level.
- If living in a deprived area, 37 times more likely to die as a result from exposure to smoke, fire or flames than children with parents in higher managerial or professional occupations.
- Over one third of stillbirths and neonatal deaths were born to mothers in most deprived quintile. Maternal mental health is one of the strongest predictors on child outcomes
- Tackling social exclusion and reducing health inequalities is a priority for Government

Effective parenting improves outcomes for children

- Effective parenting can protect against the risks of growing up poor or in a deprived neighbourhood, and reduce the likelihood of anti-social behaviour and crime
- Impacts on educational attainment are particularly well documented:
 - Parental interest in education is four times more important than SES factors in influencing attainment at 16
 - Parental involvement has a bigger impact on attainment at 7 & 11 than the quality of the school even controlling for social class
- Provides a strong rationale for government intervention to support those parents who are struggling
- And to challenge parents who are unable or unwilling to meet these responsibilities

'Put succinctly, parents create people. It is the entrusted and abiding task of parents to prepare their offspring for the physical, psychosocial and economic conditions in which they will eventually fare, and it is hoped, flourish'
(Bornstein, 2002)

Developing the potential of parenting and family support to improve child outcomes

- Parenting support programmes can make an enormous difference
 - 11 out of 15 studies showed significant long term effects between one and 10 years on children's behaviour

- One systematic review found that group parenting programmes for parents of three to ten year olds produced improvements in behaviour that were maintained at six months, one two and three years
- Despite this:
 - Problems with supply and availability
 - Agencies don't refer
 - Or don't refer early enough
 - Targeting & reach
 - Issues about quality of practice

So what are we doing to expand parenting and family support?

Three main strands of activity:

- Supporting local authorities to develop parenting support
- Developing the workforce
- Increasing targeted provision

Supporting local authorities

- In 2006 LAs asked to appoint single commissioners of parenting support and to develop a parenting strategy by March 08
- Majority of LAs have strategies in place and are now moving to an implementation phase
- Parenting Implementation Project to test effective practice in developing parenting strategies to develop a national framework for all LAs

Supporting the workforce

- The National Academy for Parenting Practitioners
 - Mission - To transform the quality and size of the parenting workforce across England so that parents can get the help they need to raise their children well
 - Training in evidence based programmes & skills needed to work with parents
 - Provide ongoing support to practitioners; through individual and group consultancy and online services.
 - Developing the evidence base
- Plus feeding into wider workforce development e.g. Children's Workforce Strategy for 2020

Parenting Early Intervention Pathfinder roll out

- To support for the parents of 8 -13 yr olds at risk of negative outcomes
- 18 pilots 2006-2008 shown to be a success with high levels of gains for parents and their children
- An additional 24 LAs in 2008/9
- Currently working on plans for further roll out
- Expected that the majority of LAs will receive PEIP funding by 2010
- Improving delivery
 - more firmly to the roll out of extended schools
 - wider range of parenting programmes

- Ensuring LAs develop their systems to deliver better support (not just about training more practitioners to deliver)

Two parenting practitioners in each local authority

- Respect practitioners in 77 areas to support the parents of children and young people involved in or at risk of anti-social behaviour.
- £34m Children's plan commitment to build on this by putting 2 parenting advisers in every local authority.
- Targeting parents with problems known to put their children at risk, for example, parents who are offenders, have mental health problems or with drug and alcohol problems.
- Currently being recruited.

But of course some families need more than just parenting support ...

Too often parents pass their own problems onto their children, creating a never ending cycle, generation after generation which becomes difficult to break. We are still not doing enough to interrupt inter-generational patterns of social exclusion.

- 63% of boys with convicted fathers go on to be convicted themselves
- Parental alcohol misuse is a factor in more than 50% of child protection cases (and there are 350,000 children with drug addicted parents/1m with alcohol addicted parents)
- 1:4 children witnessing domestic violence have serious social and behavioural problems.
- Children from the 5% most disadvantaged households are more than 50 times more likely to have multiple problems at age 30 than those from the top 50% of households.

Rather than waiting for the first signs of risk to emerge in children, we could do more to predict future risk by picking up signals from the family as well as a child

Such as the 2% or 140,000 families with children experiencing 5 or more disadvantages

Percentage of families with children experiencing 5 or more disadvantages

2001	2.2
2002	2.1
2003	2.0
2004	1.9
2005	2.0

The consistency of this figure over 2001 – 2004 suggests that improvements such as the reduction in child poverty may not be reaching such families.

Basket of indicators of disadvantages includes;

- No parent in the family is in work
- Family lives in poor quality or overcrowded housing
- No parent has any qualifications
- Mother has mental health problems

- At least one parent has a long standing limiting illness, disability or infirmity
- Family has low income (below 60% median)
- Family cannot afford a number of food and clothing items.

Time to ‘think family’

Systems change

- Changes to delivery systems and workforce culture to ensure consideration of the family context to need
- Critical to earlier and more effective intervention with families at risk
- 15 Family Pathfinders testing how this might be implemented.

Whole Family Support

- Need for more provision to deal with risk in families and how it inter relates
- Whole family support available at different levels
- Including very intensive support (building on the FIP model) for the most risky families.

Improving the response of services and systems to vulnerable families

Identification – Better systems for identifying and engaging families at risk (those with multiple and complex problems putting their children at risk of poor outcomes)

Whole Family Assessment – Building on the CAF, which looks at the needs, strengths and interrelation of problems of the whole family

Multi Agency Support Plan – Managed by lead workers who case work families, working directly with them and co-ordinating other service involvement

Improved Information Sharing – to enable early identification and interventions

Joined up Planning and Commissioning – to ensure the full range of evidence based programmes and interventions to meet family needs

Integration between Adult and Children’s Services – at all levels of local services – such as clear accountability for families through joined-up governance to and a common vision and agreed outcomes for families across services as part of the LAA process.

Family Intervention Projects (FIPs)

- There are currently 65 FIPs dealing with anti-social families in the UK.
- FIPs are projects which challenge and support families at different levels to change – working with the whole family.
- They gain the agreement of the family to a range of behavioural changes and engagement in interventions.
- Accredited parenting programmes are delivered and services (such as health) are brought in and coordinated around the family, based on the Dundee model.

Family Intervention Project Model

- FIP team, Key worker 'grips' the family & builds on strengths, non-stigmatising
- Nominated health professional (NHP), to signpost and make appropriate referral to health services
- Multi-agency panel

Expansion of Family Intervention Projects to reach 20,000 families by 2011

“Child Poverty FIPS”

- Announced in 2008 budget
- 10 projects to be launched in October 2008
- Further expansion over 09 -12

Testing the model with families with multiple problems other than anti-social behaviour e.g. intergenerational poverty and worklessness, substance misuse etc

“Crime Prevention FIPS”

- Announced in Youth Crime Action Plan
- A project in every local authority
- 2008 – 20 projects expanded and 48 projects planned
- National roll out over 09-12

Focus on specific types of risk in families e.g. prolific parental offending, domestic violence etc. Focus on specific age bands of children e.g. 0-5, 5-10 or 10+

FIPs-health impact in families

- 80% of parents had poor health/mental health problems
- 47% of families affected by domestic violence, high number of children at risk
- High proportion of children with ADHD, emotional & other problems
- Over 50% of the children are obese and overweight, with very poor nutrition

Role of the Nominated Health Professional - where health works well

- Participation on steering group and multi-agency panel;
- Effective communication between agencies & whole family assessment, including age appropriate children's services;
- Links into teenage pregnancy, DAT, school nurses, GPs, psychologists, paediatricians, CAHMS and health visitors which help to create networks, nutrition and obesity prevention.
- Knowledge of commissioning and levers

Where do we need to get to?

An integrated and appropriate service response to **all** families at risk

How will this be achieved?

- . Joined up Family Intervention Project type provision sufficient to meet the needs of the most extreme families (whatever their combinations of problems)
- . Changes in attitudes, culture and behaviour at local level and on the front line (achieved by 'Think Family', workforce reform and Children's Trusts) to **identify** and **intervene early** with **all** families at risk

However – need to be realistic. This is a massive change process that will take significant investment and time to deliver. But the potential gains are huge.

Morning Q and A Session

Mental Health and Family

Notes: Jean Healy

Neil Sanyal said teams were becoming ever more specialist and fragmented. How can you get people to work together again with a focus on the family?

Claire Barcham (CB) recognised this from her perspective in adult social care. She said there was a need to have better links to all social care colleagues. We needed to borrow from President Clinton – it's the family, stupid!

Gill Strachan (GS) said that there were strategic commitments with money from Department of Health behind them. Health was the hardest one to crack – where do you go in? She said the need was to change workforce culture and training. It will take a long time to get there as trying to reverse the system will take time.

Nicky Stanley asked about nominated health professionals in FIPS – are they able to access mental health services for families. GS said that this was the most difficult part. Some FIPS are doing a fantastic job in fast tracking but there was not enough access to mental health services. Some progress had taken place very recently in developing pathways to mental health for FIPS families.

Anita Wilson – Carer with links to Hallam University- asked is the public access system going to be easier for families in health and social care?

GS agreed that we need to provide a world class public service. Need to be telling families and professionals to Think Family. Service users should have access to all services and there should be no wrong door.

CB – said that it was difficult to get access. Families should know that they can request a mental health assessment on the basis that their mental health is deteriorating. This is a right.

Amynta Cardwell asked how to get the Think Family ethos into the ethos of adult mental health services. While a family focus was growing in CAMHS services dealing with adult services was like dealing with Planet ZOG! She wondered who had the skills to engage young carers and how to get this skill.

CB has been working with AMHPs and the competencies required for the role. Training is needed in work with children to build confidences at both commissioner and practitioner level.

GS – Family pathfinders cover 15 sites and only 6 sites for young carers, so we know it is an issue and need to bridge gap. Joint commissioners need to be set up for children's services.

Keir Parsons asked about the CAF process and how we could move to a family CAF.

GS said there was no timescale but that there was a sense of urgency. FIPS projects had adapted CAF to suit families. There was a dire need for more family assessments and there was a need to do a national piece of work. Workers were not good at capturing family issues – and there needed to be a massive push on this.

Mike O'Connor asked about the role and profile of the health professional in FIPS teams.

GS said there were a variety of professional groups- Midwifery, nursing, paediatricians taking on this role.

CAPE Project workshop – supporting families affected by parental mental illness

Richard Anderson and Ali Coton – The Cape Project
Notes; Vicky Nicholls

Background

The CAPE Project has been funded since 2005 following concerns about the needs of children living in the borough of Greenwich living with a parent or carer suffering from mental ill-health. In particular a Serious Case Review following the death of a child highlighted that services weren't joined up – divided and specialist within the Trust, safeguarding children's services, and CAMHS. National Children's Bureau (NCB) was commissioned to undertake a needs assessment and found parental mental illness was over-represented in child protection case conferences, on the register and where children were accommodated.

Considerable talking with different agencies followed to focus minds on joined up thinking. A steering group was set up with representation from adults and children's services. A database of needs was established. Three-year funding was successfully obtained from the Gatsby Charitable Foundation.

The Project has been heavily involved with the development of the SCIE guidelines as there is so little evidence about what works in interventions with families. Their approach will be cited in guidelines.

The Project aims to work directly with families as well as offering training and consultation, working in partnership with the voluntary and statutory sector. At peak had seven plus staff, with everyone contributing to different aspects of work. Diverse team, including two CPNs, two children and families social workers, CAMHS clinical psychologist and family therapist.

Project's work

Work with families started as short-term but became longer term! To be referred by statutory agency parent had to have significant mental health problem. Not all at child protection level (2/3 involved with children's services), and some kept out of this level through preventative work. Very high threshold for children's services in Greenwich.

Project has worked in number of ways, including:

- facilitating contact with parent when in hospital
- facilitating discharge re needs of children as well as parent
- building links between family members
- trying to make admissions into care planned rather than crisis
- practical help e.g. getting children to school (might be concerned about leaving their parent at home)

One participant asked about childcare when parent in hospital. Project has access to specialist childminders. They might for example flag up concerns about mum's wellbeing - much less intimidating than social worker. They can model good parenting, and childminder might say there's a baby massage class why don't you come with me. More like kinship or peer care. Paid for by

CAPE. Meet up regularly for training organised via children's information services. Parents can also get e.g. access to therapy sessions.

Inter-professional links

Very proactive with local services, Ali was 'like a dog with a bone', going in to teams, having a link worker in each team to repeat 'and do they have children?' question. Also did this on wards. Undertook joint visits to families, barriers can come down when people sitting in same room. People shared phone numbers and could call afterwards. Also had benefits for health visiting and maternity services: project offered training for health visitors, social workers and midwives, tailored to their needs e.g. took to them if they couldn't get away from locality, and took leaflets into team meetings to ask if people were going to training and knew about the research.

Perinatal service

Developed a local perinatal service on goodwill. No previous policy on what to do if woman with history of mental illness became pregnant. Now women in touch with secondary services stay under those services. Also have one afternoon clinic a week with consultant obstetrician and mental health workers. Very popular. Lots of women identified as developing mental health problems during pregnancy or at risk having had postnatal depression after earlier pregnancy – with service provided women go on to have better bonding with babies and better outcomes than in previous pregnancies. Making plans ahead means fears about baby being taken away are not so dominant. Parents can identify relatives or others to help care for baby.

Discussion

Participant from Childrens Society – training work in partnership with Princes Royal Trust for Carers in nine local authorities. All say they need specialist training. Links with CAPE project and national PMHCWN pool of trainers discussed.

Joint commissioning seen as crucial. Difference made by physical presence reiterated – when person with family perspective seen in team's office (e.g. adult mental health; CAMHS; children's services) they are reminded to think 'oh we've got a family here' and this prompts action.

In Poole, Dorset lots of mothers referred across because ground down by children's needs e.g. children with ADHD, Aspergers, and very few other services for mothers. Very little money available once child reaches 18.

Changes

Task was embedding good practice. Some changes cited by CAPE Project e.g. Trust Director sits on safeguarding panels, issues are kept on agenda. CPNs know their clients are parents, have learnt new skills, will sit down with children and do drawing. Take skills back to their teams.

Importance of liaison re checking across teams e.g. does someone need referral. Tease out information about whole situation, role for Project as interpreter to help people work out language to use to get to root of concern.

Evaluation

Very positive evaluation of CAPE Project by NCB. Included talking to families, six long interviews. Children either didn't want to speak to researchers or were too young. Found a 'can do' attitude and strong support for multi-agency working. Well respected and valued service. Concerns that high staff turnover might mean lessons get lost.

CAPE worked with 20 – 30 families at a time at peak. Attitude that would work with anybody, help people fill in forms, talk to grandparents. Most work in people's homes, or e.g. CPN currently going out with one young person in his car.

Project fell down re reaching hard-to-reach families because of referral criteria, had to come in via another service. Nonetheless have seen more BME families than other services because of flexibility and understanding about different cultures, also having a multi-cultural team. Less fear of children being taken away with Project. Asked other services to refer people on where have been through big traumas and maybe seemed to be managing but mental health concerns. Involvement with project has stopped it getting worse.

Notes from Presentation: Supporting Families Affected by Parental Mental Illness – The Cape Project

Background / Context

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.

The fact that a parent experiences a mental illness does not automatically imply a negative impact on the parent–child relationship, nor does it suggest inevitable parental inability to parent and to adequately meet a child's needs.

However, a conservative estimate is that a third of children living with a mentally ill parent will themselves develop significant psychological problems or disorders.

A further third will develop less severe emotional / behavioural difficulties which may nevertheless be significant for their longer term development.

Crossing Bridges

The mental health and well-being of children and adults within families in which an adult carer is mentally ill, are intimately linked in at least three ways:

- Parental mental illness can adversely affect the development and in some cases the safety of children
- Growing up with a mentally ill parent can have a negative influence in the quality of that person's adjustment in adulthood, including their transition to parenthood
- Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill-health in the parents/cares.

Crossing Bridges

Research

Falkov's (1996) study of fatal child abuse found at least a third of parents had a psychiatric disorder.

Parental Mental Illness was a factor in 55% of Serious Case Reviews in which a child died or was seriously injured.
DSCF 2008

Challenges in London

Poverty (inner London 51% children in poverty vs 28% UK)

High mobility between boroughs

Twice as many homeless YP as the rest of the UK

¼ million refugee children

High rates adult and child mental health problems

High ethnic diversity

London Borough of Greenwich

Approx 230,000 people live in Greenwich (2001 census)

Approx 63,000 children and YP (expected to rise to 72,000 by 2016)

23% of population from ethnic minority background (8.7% nationally)

Nearly 10,000 lone parent households with dependent children (5th highest of 376 census areas)

Over 37,000 people with limiting long term illness (4th highest in London)

1,500 Children and Families requiring intensive or specialist support at any one time.

Greenwich is the 41st most deprived local authority in England and Wales (2004 Index of Multiple Deprivation)

How did the CAPE Project come about?

Professionals from Social Services Health and Education had become increasingly aware of the needs of children living with a parent or carer suffering from mental ill health.

The need was highlighted further by a Serious Case Review in 2002.

NCB needs analysis in Greenwich identified high levels of need. Parental mental illness over represented in Child Protection Case Conferences, children on register, children accommodated.

Joint proposal from Greenwich Social Services, PCT & Oxleas NHS Foundation Trust

Gatsby Charitable Foundation provided funding in April 2005

Service Provision

Adult Mental Health services and Children's services have become increasingly separate.

The raised thresholds of statutory services mean there are less early interventions / preventative supports.

Adult Mental Health practitioners find themselves carrying cases where there are concerns about children.

Children's service practitioners unable to access a mental health service for parents/carers.

The CAPE Project

A joint Oxleas NHS Foundation Trust/Greenwich Children's Services parental mental health service in Greenwich.

The Project is funded by the Gatsby Charitable Foundation.

The multi-disciplinary project aims to provide integrated services to families where there is a parent or carer with severe and / or enduring mental health problems.

Team: Social workers, CPNs, Clinical Psychology, Family Therapy.

Aims of the Project (1)

Service Delivery

- Direct work with families
- Consultation / training
- Working in partnership with the voluntary and statutory sector
- "Changing the culture"

Aims of the Project (2)

Through direct and indirect work the CAPE Project will undertake a range of interventions and activities with the aims and objectives of:

- Meeting the specific needs of adults with severe and / or enduring mental illness who are parents/carers.
- Providing a targeted service for children and their parents/carers.
- Encouraging positive attachments and resilience and strengthening family relationships.
- Raising awareness of the impact of parental mental illness on families.
- Improving communication and joint working between the agencies involved with this service user group.
- Reducing the number of referrals to children and families and adult mental health services which result from crises.
- Reducing the number of emergency / unplanned placements of children.
- Reducing the number of emergency / unplanned hospital admissions of adult parents/carers.
- Providing services which meets the needs of the whole community and to increase confidence in, and take up of services by users from black and minority ethnic communities and other disadvantaged groups in the borough.

Consultation

Since April 2005 the project has been providing case consultation and advice to colleagues in AMH and children's teams.

Has advised at case conferences/ professionals meetings/strategy meetings.

Has chaired professionals meetings in complex cases.

Has undertaken joint assessments with colleagues.

The project has developed a database of all families known to both adult mental health and children & families services.

Maintaining links

Each CAPE Project practitioner carries a link worker role with all the adult community mental health teams, the in-patient and perinatal service. All community referral meetings and ward meetings are attended and advice is given about the management of cases where the referred adult has caring responsibility for children.

The project team maintains close links with the children's social work teams and CAMHS

Training

The CAPE Project delivers training around basic mental health awareness, parental mental illness, child protection and joint working to various groups including midwives, foster carers, inpatient staff, psychiatrists, Family Group Conference chairs, and on behalf of the Safeguarding Children Board. The CAPE Project supports the training section regarding the delivery of joint training.

Direct work with families

Referred by statutory agencies
Intensive support at the time it is needed
Flexibility
Responsive to need
Multi-professional staffing

Joint Working Protocols

The CAPE Project has developed joint working protocols between adult mental health, children and families and maternity services. All agencies have signed up to the protocols which are now in use across Greenwich.

'TIME' Perinatal Clinic

The CAPE Project has initiated, and in partnership with adult psychiatry, midwifery and obstetrics, developed a perinatal clinic offering a specialist service to pregnant women at risk of developing mental health difficulties during pregnancy or post-natally.

The clinic, which opened in January 2006, is staffed by a consultant obstetrician, a psychiatrist, specialist midwives and a CAPE Project practitioner.

A recent audit of The Time Clinic shows we are meeting most standards as set down in the recent NICE Guidelines for Perinatal Mental Health.

Changing the mainstream

The CAPE Project has contributed to the soon to be published SCIE / NICE good practice guidelines for working with families affected by parental mental illness.

The CAPE Project has been asked to present its work at conferences nationally and been contacted for advice from agencies internationally.

What parents want for their children

- Opportunities for children to talk about fears, confusion and guilt.

- Opportunities for children to meet people (adults whom they can trust) and to participate in activities where they can meet other children.
- Provision of explanations about events and circumstances surrounding parental illness.
- Continuity of care and minimal disruption of routines during crisis, including hospitalisation of parent / carer.

What parents want for themselves

- Good quality care and support to meet the needs of their children.
- More understanding and less stigma and discrimination by communities and society in general about mental illness.
- Parent support groups.
- Support in looking after their children.
- Ongoing support from services beyond the acute crisis so that continuity in relationships with key-workers can occur.

What children want

- Information about the illness and prognosis.
- Recognition of their role in the family.
- Practical and domestic help.
- A contact person in the event of a crisis regarding parent.
- Someone to talk with – not necessarily formal counselling.

What was revealed was a real fear amongst parents that contact with social services and an admission of mental health difficulties would result in their children being removed.

External Evaluation -Findings

Evaluation

The National Children's Bureau was commissioned to undertake a wide-ranging evaluation.

October 2006 – March 2008

Methodology

- Analysis of monitoring data.
- Feedback from training.
- Face-to-face interviews with staff, families and key stakeholders.
- Telephone interviews with users of the projects consultancy service.
- Survey of professionals and practitioners working in Greenwich.

Key Findings

'The CAPE Project has achieved much of what it set out to do, in raising awareness and understanding of the impact of Parental Mental Illness on children and families.'

'The CAPE Project is reported to have had a positive impact on parents, children and relationships within families'

.....has encouraged and supported agencies to work together to support such families.'

...has responded to emerging needs, for example by helping to establish the perinatal TIME Clinic'

'The CAPE Project is a good example of a service that cuts across traditional service boundaries.'

'The project is well respected and valued by local practitioners and agencies and its mode of operation is in line with current policies relating to family support and partnership working.'

Future Planning

Commissioners will need to consider how to keep the issue of parental mental illness current and embedded in good practice.

The evaluation identified a need for holistic and intensive work with families.

This is a specialised service that doesn't currently fit mainstream service remits.

Keeping the Family in Mind...a collaborative approach.

Louise Wardale, Keeping the Family in Mind Co-ordinator, Barnardo's Liverpool and Carol Bernard, Service Director – Adult Mental Health, Mersey Care NHS Trust.

Notes: Vicki Coppock (SPN Exec)

Louise gave a **summary of the context in which the 'Keeping the Family in Mind' Project emerged**. The Project arose in the late 1990s out of innovative work being done by Barnardo's 'Action with Young Carers' Project in Liverpool responding to the needs of children and young people in families where there was a mentally ill parent.

A partnership was developed between Barnardo's and the local Mental Health Trust (now Mersey Care) to undertake some initial scoping research from which clear recommendations emerged. An application for Children's Fund monies was successful and was used to kick start the development of a strategic approach to promoting connections between a wide range of contacts and adult mental health services.

In many respects, Louise commented **'Keeping the Family in Mind' anticipated and predates the current initiatives around 'Think Family'**.

Louise went on to identify the **vital ingredients to the success of the Project**:

- Participation and active listening to children and young people
- Getting all the main services to join in and begin the 'journey'
- Sharing the vision at every level to work towards better outcomes for the family – 'Keeping the Family in Mind' is now a 'movement' across Liverpool
- The power of the collective voice producing a 'critical mass' to make things happen
- Working proactively to address inequalities and seeing this as the cornerstone or platform from which things can be developed further

Louise emphasised how important the **collaborative approach** was from the outset as it enabled access to senior managers within the various organisations. She reflected that it was both a 'top down and bottom up' approach.

Louise described some of the specific service **improvements and outcomes from the 'Keeping the Family in Mind' Project**. She outlined the development of the **'Jelly Baby Logo'** which is now used as a 'kite mark' illustrating a standard for provision and practice.

In the late 1990s family rooms could not be found on psychiatric wards and this had been identified as a serious concern by those families involved with Barnardo's 'Action with Young Carers' Project. The development of a family room at one of the local psychiatric units was a major step forward and these

have now been extended across the Mersey Care Trust. The children at the Project designed the Jelly Baby Logo and this is used on posters and child-friendly literature in the hospitals to signify family orientated services. A Young Carers Mental Health Resource Pack has also been developed. The logo has become a 'brand' and sends a powerful message at different levels – children and young people, families and staff – regarding the importance of being child and family centred.

Louise noted that Barnardo's aimed to embed the 'Keeping the Family in Mind' approach into the culture of services. She reflected that a great deal has been achieved but that it is still a 'work in progress'.

Carol described how the Project went about increasing the **visibility of and identification with 'Keeping the Family in Mind'**. A national anti-stigma postcard campaign was one approach. Postcards with important messages about mental health and stigma were posted to 1 in 4 families in the Merseyside area. Larger poster versions were posted on billboards and even distributed to some of the soap operas so they could be seen in various scenes.

Another approach that has been developed is the adaptation of the 'message in a bottle' idea whereby an advanced statement is made containing details of what the family has agreed about what should happen if a parent goes into hospital. This has been piloted in one of the mental health teams and has had a positive response. It will now be rolled out across the Trust.

Carol went on to outline some specific measures taken to improve **access to support and services** including:

- Identification of parents with children under 5 and request to health visitors for follow-up
- Work with extended schools and children's centres
- Spotlight on gaps between children's and adults services

In terms of **improved identification and assessment** Louise explained how the Project uses the Statutory Young Carers Assessment as a vehicle to achieve this since these children often do not meet the threshold for children's social care. A 'joint assessment' policy has been developed strategically and was piloted with children and families. Adult mental health professionals undertake this - a protocol has been developed and is implemented alongside the CAF to provide a distinct 'care pathway'.

Carol indicated how the 'Keeping the Family in Mind' Project has contributed to a **more confident and supported workforce** as follows:

- Heightened awareness and motivation through induction training
- Ability to respond to need through the provision of Family Rooms and bespoke information to give to parents and children
- Shared responsibilities through joint Young Carer Assessment training

- Robust policies and procedures - 'Keeping the Family in Mind' is embedded in all training, policies and procedures

Louise and Carol then presented a short video made by children, young people and parents from the Project entitled 'Telling like it is' before opening up the workshop for questions / discussion.

Discussion – a.m.

One participant asked how the Project deals with situations where a parent does not want practitioners to discuss their mental health condition with their child(ren)?

Louise responded by saying that the Project works hard to encourage and support parents to be open with their child(ren). She emphasised that this can often be achieved through a process of careful negotiation; not rushing parents into a situation that they are uncomfortable with. She also explained how practitioners can find a form of words to both ensure that children and young people are included and be faithful to the wishes of parents.

Another participant, a carer support worker from the voluntary sector, commented that he worked within the Mersey Care region and whilst he appreciated the progress made in this area he felt that there was a long way to go. The positive philosophy presented was not always evident in practice – for example:

- *carers support assessments being ignored*
- *people coming off wards and not knowing about Projects*
- *backlogs of CPA assessments*

He suggested that Mersey Care might explore the scope for voluntary organisations such as his to be commissioned by the local authority to undertake these assessments?

Carol assured the participant that she would follow this up

Discussion – p.m.

One participant asked how funding for the Project works?

Louise explained that her post is funded through adult social care with a contribution from Barnardo's. The Barnardos Action with Young Carers Service as a whole is funded via a 50:50 arrangement between Liverpool City Council and Barnardo's.

Another participant observed that the Project clearly relied on the inspiring commitment of individuals to make it work, along with a designated post, and so is it replicable?

Carol explained that it is more about identifying who your champions might be (and these are not always the most obvious people) who have influence. She agrees that personal drivers are important, noting how experiences you observe change your own impetus as a practitioner. She re-emphasised the necessity of a 'bottom up and top down' approach, bringing people together in the middle. The policy drivers are also coming through now more explicitly (SCIE/NICE Guidelines due out soon).

Mersey Care and 'Keeping the Family in Mind' have also set up a 'Family Collaborative' focusing on learning cycles – Plan, Do, Study, Act – important themes for good practice have been developed out of this getting together. Carol says you just need to keep chipping away and doing what you can. She also noted that Women's Leads can be very useful allies. Louise also stated that there is a Safeguarding Leads in mental health trusts network and again the safeguarding leads are key to the developments

Another participant observed how it is not just about identifying people but also giving them solutions so that they can drive things forward quicker.

Louise noted how the development of the Family Rooms has actually changed the 'culture' within Mersey Care so that this is seen as part of the recovery process. The staff are more attuned to the needs of children and young people and children's services.

Louise and Carol acknowledged that there is scope for things to be improved even further. They explained that the strategic approach is currently being expanded to a more senior level making closer communication even more important. They also explained how Liverpool is going to be one of the five National Guidelines Implementation Sites for the forthcoming National Joint Guidelines for Parental Mental Health and Child Welfare (SCIE/NICE). The 10 Messages from Liverpool young carers and family room developments are highlighted as best practice in the new CPA Guidance which has a satellite document specifically on Parents with mental health problems and their children.

The workshop concluded with a 3 minute video from the NHS Centre for Involvement which featured the collaboration between Barnardos and Mersey Care to develop family rooms and how service users and their children were at the heart of the initiatives.

Useful References and Resources:

DH/SCIE/CSIP/NW Development Centre (April 2008) CARE PROGRAMME APPROACH (CPA) BRIEFING: Parents with mental health problems and their children

Download at <http://www.nimhe.csip.org.uk/silo/files/cpa-briefing-supporting-parents-with-mental-health-problems.pdf>

Family Minded: supporting children in families affected by mental illness - June 2008

What is it like to be a child with a parent who is mentally ill - and how does Barnardo's make a difference? This report looks at the issues involved and recommends changes to the help families are given.

[Download this report for FREE \(PDF\)](http://www.barnardos.org.uk/family_minded_report.pdf)
http://www.barnardos.org.uk/family_minded_report.pdf

Parents in Hospital: How mental health services can best promote family contact when a parent is in hospital July 2007

A stay in hospital can represent a significant crisis, not just in terms of a parent's individual mental health but of family life overall, and may have long term repercussions beyond the period of hospitalisation itself. The findings of this report suggest that this can be re-framed as an opportunity for services to provide more holistic care. To get a copy of this report email barbara.robinson@barnardos.org.uk OR

[Download the full report for FREE](#) (PDF)

http://www.barnardos.org.uk/parents_in_hospital_final_report_july_2007.pdf

[Download the summary for FREE](#) (PDF)

http://www.barnardos.org.uk/parents_in_hospital_summary_report_july_2007.pdf

SCIE Research briefing 24: Experiences of children and young people caring for a parent with a mental health problem

Download for FREE

<http://www.scie.org.uk/publications/briefings/files/briefing24.pdf>.

Keeping the family in mind - resource pack

The resource pack is aimed at anyone who works with parents with mental health difficulties, their children and their families. It is designed to raise awareness of the issues that families face. All the resources have been written and produced with the participation of children and young people. The pack costs £35 plus p&p.

For children's sake - anti-stigma pack

A set of postcards and posters featuring hard-hitting messages about the effect on children of stigma towards mental illness. In the words of children and young people who care for parents with mental health problems, these materials powerfully illustrate the need for support for their families, not scorn. The pack, useful for display, training and education, contains ten postcards with three as feature posters.

To order either of these email louise.wardale@barnardos.org.uk

Keeping the Family in Mind – a Collaborative Approach

Summary

- Key ingredients to working collaboratively
- Improvements and outcomes
- 'Telling it like it is' and NHS Centre DVDs
- Future direction

A taste of some of the vital ingredients

- Participation and active learning to children, young people and their families
- A journey – lots of people joined along the way
- Sharing the vision
- Influencing shared agencies but we had to know what they were!
- Collective voice, recognising the different starting points for different organisations (children's/adults)
- Working proactively to address inequalities ie Participation, equality and partnerships

So what have been the improvements and outcomes?

The Jelly Baby Logo

- Kite mark illustrating family orientated services
- Family rooms and child friendly literature
- Logo designed by a young carer

Culture Change

"What this dvd demonstrates is that partnership working can make a difference- the outcome for individuals and their families is testimony to this"
Joe Blott – AED Liverpool City Council, Keeping the Family in Mind Collaborative Conference October 2008-12-05

"The Video really brought the child's experiences to the forefront and helped clinicians adopt a more family-centred approach". P18 Mental Health Today May 2008

"Who would have thought a children's organisation and a mental health trust would work so well together?" – Alan Yates – CEO Mersey Care, July 2008, personal communication to Barnardos.

Increased visibility and improved identification

National post card campaign
Message in a Bottle

Improving Access to Support and Services

- Identification of parents with children under 5 and request to health visitors for follow up
- Work with extended schools and children's centres
- Spotlight on gaps between children's and adults services

Improved Identification and Assessment

- Liverpool and Sefton wide strategy group
- Joint Young Carer Assessment policy and procedures
- Implementation of the CAF
- Design and implementation of a care pathway
- Evaluation of impact and outcomes (Sheffield University)

A more confident and supported workforce

- Heightened awareness and motivation through induction training
- Ability to respond to need through the provision of Family rooms and bespoke information to give to parents and children.
- Shared responsibilities through joint Young Carer Assessment training
- Robust policies and procedures.

Keeping the Family in Mind Resource Pack

New Types of Service Provision

Family rooms have been mainstreamed

- 11 in Mersey Care NHS Trust
- Kite marked
- External and internally evaluated
- Award-winning
- A source of organisational pride

Future Direction

- Increased desire to work more closely together in identifying the strengths and opportunities for improvement across services in order to achieve better outcomes for affected families.
- A Young Carers and their Families strategy group being established by Liverpool City Council facilitated jointly between Adult's and Children's Services.
- CPA Guidance and National Guidelines implementation site.

Contact Details

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Building Bridges – Finding a Way to positive outcomes for families

Rose de Paeztron, Head of Strategic Development, Family Action

Notes: Jean Healy

Rose said that Building Bridges had 14 services in England. She spoke of the 2007 independent evaluation of Family Action's Building Bridges services by Jenny Morris available on the Family Action website www.family-action.org.uk .which looked at the work from the perspectives of

Adult

Children

Education

Voluntary sector

Service User

The impact on parents is less talked about, consisting often of stigma and fear amongst other elements. Families have a sense of being on trial.

Building Bridges is an outreach model, providing family support within people's homes and communities. . The team works alongside other services to reduce gaps in services though this still remains a challenge. BB values the importance of the voluntary sector in hard to reach families and "goes to where people are"

Working with BME communities is crucial in breaking down barriers. Family support workers (FSWs) are involved in family activities and outings, establishing boundaries and routines within the home, modelling play with the children, accompanying to appointments and liaising with other agencies in crisis prevention. They provide containment, parents can then better contain the feelings of their children. FSWs also provide advocacy, for example liaising with schools. They can encourage someone from the school to meet with the parents and engage with young carers. BB encourages onward development, e.g. sometimes service users go on to befriend others new to the service.

Rose spoke of Nadia and Hari. Nadia, in her late 20s suffered from severe Post Natal Depression. She was discharged from hospital after two weeks and suffered a marital breakdown. She was referred to BB when Hari was 9 months and placed on the child protection register. At this time Nadia was housebound. Hari had a nursery place, but Nadia was unable to take him. The BB worker worked with Nadia in enabling her to take Hari to nursery. She also engaged Hari in play, allowed other professionals in and agreed that they were to be allowed in the child protection plan.

After three years, Hari is in school and Nadia is taking him 3 of the 5 days. He is coming off the protection register soon.

The evaluation and outcomes slide shows a picture by a young service user of her mum. The flies surrounding her are "depression flies"

The evaluation works by showing the issues but is not complete. Embedding system of evaluation, where can learn from and know what to change. The tools used look at goals and progress made.

Evaluation- key stages part 1

Identifying appropriate tools is a challenge – need to choose tools already recognised externally which can be administered by lay people. Consultation is of great importance in developing the system and that all are involved, not just the organisation. Training is important when rolling out to ensure that people are comfortable administering the tools. This is done through role play. Rose said it was important to have a pilot phase in any evaluation.

14 Services refer to BB, 9 of which shown on slide. Some services only take referrals from adult mental health services.

Evaluation tools

These should cover what information we want to capture ie who is coming, services are client led and what we want to achieve. The goal should be bite size, for example a parent meeting a teacher for the child to go back to school. There are two questionnaires for parents, the parental satisfaction scales and the index of family relationships. These are not as culturally sensitive as they could be, but Rose was hopeful for more funding to develop a more culturally sensitive tool. External tools are used, giving recognition and credence.

With children under 11 the Depression Rating Scale is used and for over 11's, Rosenberg's Self Esteem rating. Need to evaluate with one adult and one child in the family and on a case by case basis.

Key stages part II

This involves timing, reviewing and questionnaire. Evaluations are carried out at the beginning of work, the end of work and 6 months after the family have disengaged.

When building a database, the data should be coherent and checked for quality and that it makes sense.

Make sure all are involved – owning the project and making sure they get something out of the other end. This is challenging for practitioners but ensures that they see the purpose, value and their part in it. Post 6 month follow up can sometimes be done by telephone, although most are face to face.

Outcomes Model

Rose explained the slide showing the outcomes model. The aim is what you are trying to do, the outcomes are the change that will happen as a result of the activities and the objectives are what you are going to do. The bottom line objectives can be linked back to aims to ensure they fit.

She spoke of the importance of evaluation tools and making them work for you. Sometimes when thinking of objectives, they may not meet the aims and will need to be adjusted. It is useful to play around with these when developing outcomes and outputs.

Group Exercise.

Delegates were divided into groups of three and asked to choose a project or workstream and then identify the key and specific aims, then to look at objectives and how these will be achieved.

Rose asked how people had found the exercise as a way of working and it was generally found to be very useful.

One group had used the exercise in facilitating a group of young adults with a variety of mental health problems. Their aim was to reduce the isolation of young adults and the independence of both parents and young adults.

Specific aims were:

- to increase parental freedom, or reduce the restrictive nature of the role
- to improve social contact for the young adult and
- to increase the young adults confidence.

Rose pointed out that phrasing helps in thinking the points through and that 3 – 5 aims is about right.

The objectives were to facilitate the parent and young adult to have access of other adult services, to encourage conversations to develop forums and encourage people to take risks

Another group's aims were to improve outcomes for children when parents are affected by substance abuse.

Specific aims were:-

- to engage parents in treatment for substance misuse
- Reduce impact on children and
- To break the cycle

Rose suggested changing the wording to allow the aims to be measured ie increase numbers of parents engaged in/benefiting from treatment.

Outcomes are not always positive, can also be negative and be planned or unplanned.

With this group, adult drug treatment data was required as at present didn't reflect what the service was doing. Therefore suggested objectives were

- 1 to 1 outreach working with parents and children
- To be an information link to share information with other services
- Specifics of family sessions

Rose mentioned that the Charities Evaluation Service offer a free 2 day training course on outcomes focus and if anyone required more information, to email her.

In terms of the Building Bridges model, a report was created in the summer of last year. Another analysis of data upheld these findings and the aim is to update and republish next year.

Building Bridges helps parents in that their children were not removed from the family as the work is preventative and not crisis based. It is seen as very positive and sends the message to parents that the healthiest part is that they are trying to be good parents. BB gives good anecdotal evidence and shows that hospital admissions are reduced, there are fewer separations for children and that it is good for the family as a whole. There is improved school attendance and young carers are moved out of their role. Third sector organisations are often able to engage with families as they are not seen as 'going to take my kids away' so it is easier to build trust and relationships.

Rose finished by giving her contact details and inviting delegates to contact her with any queries. She also gave details of a companion network for parents with learning disabilities. This is a mine of information and is free to join. www.right-support.org.uk

Notes from Presentation: Building Bridges – Finding a way to positive outcomes for families

Overview

- Building Bridges – what we do re evaluation and outcomes
- Working with outcomes – what do you do?
- BB findings from independent evaluation

Impact

Children

- Developmental
- Educational e.g. interaction, young carer role
- Emotional e.g. impact of insecure attachment
- Social e.g. isolation, bullying
- Cognitive e.g. motor skills, concentration

Parents

- Stigma
- Uncertainty and complexity
- Feeling “on trial about parenting abilities”
- Fear – of losing children, reality of it happening
 - of mental illness
- access and reuniting with children
- recovery impeded by anxiety

What does Building Bridges do?

- Build relationships

- Provide models of behaviour
- Monitor – manage risk
- Contain – and prevent crisis
- Information and advocacy
- Value and increase self esteem
- Opportunities to develop

Case Example: Nadia and Hari

- Severe PND
- Hospital: mistrust of statutory services
- Earning acceptance
- Identify interventions
- Focus on parent/child relationship
- Practical issues

Work at different levels

- Organisation as a whole
- Local – project
- Individual worker/service user

Building Bridges: Most common issues worked with?

Parenting	68
Emotional stress	67.5
Child Behaviour	63
Self Esteem	45
Social Isolation	45
Mental Health	43

Key Outcomes

- Increasing parental confidence
- Reducing emotional stress
- Improving child behaviour

Key stages 1

- What do we want to do?
- Qualitative and quantitative
- Identifying appropriate tools
- Consultation/ownership
- Training development
- Pilot phase

Who refers to Building Bridges?

Adult Mental Health	11%
CAMHS	3%
Education	9%
GP/Health Visitor	8%
Not known	4%
Other	9%
Self	16%
Social Services adult	1%

Social services children/family	29%
Voluntary organisation	10%

Evaluation Tools

Monitoring Form

- Profile
- Goal setting

Questionnaire

- Parents
- Children

Key Stages II

- Get going!
- Building database
- All on board
- Review
- Learn and adjust
- Analysis

Outcomes Model

Overall aim – improve life chances for parents with mental health problems and their children

Specific aims – increase parenting confidence, reduce emotional stress, improve child behaviour – outcomes

Objectives – individual outreach support, information on parenting, individual work with children, parenting group – outputs.

Outcomes I:

Characteristics critical to successful interventions:

- Close attention to *getting, keeping and engaging* parents
- A strong theory base
- Synthesis of practical and emotional support
- Working with both parents and children
- A practical, flexible and partnership approach which is valued by parents and other stakeholders

(Building Bridges, Morris J. July 2007)

Outcomes II:

Statutory Services

- A reduction in the number of children looked after
- A statistically significant reduction in the number of children on child protection plans
- A statistically significant reduction in the number of adults on CPA

Evaluation: Parents' views

- Non judgmental and flexible
- Helps children to understand mental illness
- Helps families link in with other agencies
- Prevents deterioration in family relationships

Random sample of 40 closed cases resulted in 31 interviews with parents (response rate 78%).

BB Evaluation: Other Agencies' views

- Whole family focus – services are flexible and tailored to individual families
- Ability to work with families with high levels of need, including those where children are on child protection plans
- Willingness to work with families where there are profound and enduring mental health problems
- Synthesis of practical and emotional support
- Positive working relationships with other agencies

“For families who are easier to engage there are more services. But Building Bridges works with those who are the hardest to engage with, who aren't motivated to go to a parents' group or whatever. When we agreed to fund them we agreed they would start with the harder to reach families and that's what they've delivered”.

Local authority stakeholder for BB Evaluation 2007.

For more information:

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Download Building Bridges evaluation at: www.family-action.org.uk

Join (free) Parental Mental Health Network: www.pmhcnw.org.uk

Building a Family Service

David Bailey and Amynta Cardwell from the CNWL NHS Foundation Trust:
Notes: Ciaran Healy

David and Amynta were asked what they do in the Parental Mental Health Service and discussed the importance of taking on patients from multiple sources, and dealing with them completely in-house. Constant referrals to different agencies means that people lose interest.

The PMHS is designed in response to service user views, stressing that young children who have been their parents primary carer for years cannot be frozen out when they begin receiving psychiatric help. They highlighted the importance of keeping yourself available to patients with erratic and fluctuating mental health.

The group discussed an issue raised concerning psychiatrists that work beyond their speciality (Adult – Child). Is this flexibility an asset or a worrying trend of under-funded and under-staffed organisations taking on too much? Amynta concludes that it is subjective, but that sometimes an adult gets attached to a child psychiatrist and it's important not to turn them away.

The group then discussed the level of enforcement of the confidentiality agreements. Would it aid a teacher to know more about the home – life of troubled students or should this information remain withheld?

David discussed the findings of the last year and the challenges that CAMHS faces next year. Among the outcomes were:

- Increased referrals from AMHS to CAMHS
- Reducing duplicated assessments for child / adult.
- Developing staff skill base across child / adult
- Sharing the learning

And among the challenges were:

- Identifying worrying behaviour: Don't get caught up in diagnosis when adult behaviour is directly affecting a child.
- Outcomes for who? How do commissioners measure outcomes? What do they measure?
- Identifying that an improvement in parenting skills can improve the mental state of both adult and child.

In conclusion, Amynta discussed her belief that family therapy needs to be more responsive. Therapists need to be adaptable and creative, continuously building relationships. A faster reaction is needed to designate a child as "in need" due to a parent's mental health issues. She presented a final slide entitled "beyond", discussing their long – term goals:

- Analysing and responding to findings of review: Constant consultations have a negative impact.
- Forging new partnerships e.g Perinatal, MIND, OREMI, Personality Disorder Centre: Involve everyone a patient trusts.
- Influencing partners
- Tackling workforce development issues e.g systemic skill set: People need specialised treatment. If you are referred to someone whose case does not correspond with your expertise then refer them elsewhere.

Notes from Presentation: Building a Family Service

2008

- Expanded to the south
- Engage social care e.g commissioning + Young Carers Strategy
- PMHS multi-agency cross directorate Steering Group
- Protocol for adult practitioners
- Cross-borough LSCB Training
- Collect HONOSCA's, Paddington Complexity Scale
- PMHS Review: Service user, adult staff, social care, commissioners

Outcomes

- ▣ Increasing referrals from AMHS to CAMHS
- ▣ Reducing duplicated assessments for child/adult
- ▣ Extending access for 'hard to reach families'
- ▣ Developing staff skill base across child/adult
- ▣ Utilising links: EHS, Hidden Harm (**SMS**), transition
- ▣ Consolidating multi-agency partnerships
- ▣ Modifying service involving users
- ▣ Building case for PMHS elsewhere
- ▣ Sharing the learning

Challenges

- Threshold to access adult services .. Diagnosis v behaviours + impact on children
- Threshold to access CAMHS diagnosis v prognosis given experience
- Drive to close cases + lack of fit with clients
- Outcomes for who? child or parent as reported by child/parent, adult service, commissioners
- 'Thinking Family' a priority for adult services?
- A quality of relationship issue

Beyond

- Analysing and responding to findings of review
- Forging new partnerships e.g Perinatal, MIND, OREMI, Personality Disorder Centre
- Influencing partners, CAMHS, Adult service, NHS change agents (e.g PBR, 'A new vision for mh')
- Tackling Workforce Development Issues. Systemic skill set

SCIE/NICE guidelines

Daphne McKenna – Independent Consultant to SCIE

Notes: Terry Bamford

Daphne has been involved in the steering group for the production of joint SCIE/NICE guidelines on parental mental health and child welfare.

After introductions which showed a broad spread of interests including service users, mental health workers and students, Daphne outlined the remit of the Social Care Institute for Excellence (SCIE) which was launched in 2001. It had the task of encouraging evidence based practice and disseminating good practice. All the material was available free of charge at www.scie.org.uk

In 2004 the report Social Exclusion and Mental Health said that SCIE would be commissioned to conduct a systematic review and produce new guidelines. It has been a long process. There had been reviews of research findings on the impact of mental health on parenting, the numbers of adults with mental health problems who are parents, and how good adult and children's services were at screening identifying and recording the issue. There had also been reviews of law and policy to assess whether families were at the forefront of considerations in policy. There had also been an evaluation of the effectiveness of professional training.

A practice survey had been undertaken in five pilot sites: Lewisham, Southwark, North Somerset, Birmingham and Liverpool. This had revealed that most agencies had gone beyond the awareness raising stage and were looking at how best to tackle social exclusion. But performance indicators did not reflect this work and the system lacked incentives to encourage a family focus.

Hitherto the policy emphasis had been on changing adult mental health services but Children's services too needed to be encouraged to 'think family'. The practice survey suggested that children's services were very focussed on the individual child and any new guidance needed to be directed equally to adult and children's services.

There were great problems in getting any data about the numbers of parents with mental health problems who had children. This made it difficult to have effective joint planning and commissioning. While there were inter-agency protocols they were rarely embedded in practice.

One major problem was that the Care Programme Approach and Childrens Assessment Framework did not marry up. The recent guidance on CPA had stressed engagement with the family which was welcome progress but it is likely that the guidelines will contain specific recommendations about what to do at key stages of the care pathway.

Better recording of the numbers involved was essential. The high thresholds in both children's services and adult services militated against the identification of cumulative and compounding stresses within families.

There was disappointingly little reliable evidence of what works. There were excellent individual projects but no systematic evidence. It is important to use the next few years to generate some reliable evidence about 'what works for families'. Write ups of social work projects were often 'flabby' lacking the rigour to constitute evidence.

What constituted mental health problems posed problems of definition. The emphasis on 'severe and enduring mental illness' excluded some conditions but again cumulative stressors could move less severe conditions into acute. Social exclusion approaches had to be based on early intervention and link with universal services like health and education. This required a major shift in emphasis to prevention and well-being not to the detriment of treating acute conditions but rebalancing priorities.

The key to making any structures work was getting professionals to meet and share ideas. Training too often divided professional groups rather than bringing them together. We needed to empower patients and service users as partners in services.

A strengths-based approach could help to boost resilience and reduce stressors in families. There were a number of groups who faced additional barriers to services :

Families with multiple disadvantages

Young carers of parents with mental health problems

Refugees and asylum seekers

Parents with personality disorders

Parents with mental health problems who were themselves health and social care professionals

There were wide variations in practice in children's services departments with some authorities not collecting data at all, some collecting but not collating it and a handful with reasonable records. We needed to develop incentives for hard-pressed children's services to broaden their field of vision.

The split of social services into adult and children's services reporting to different Government departments and regulated by different inspectorates had accentuated the problem but had not created it. Adult mental health workers felt deskilled in working with children and children's social workers felt unable to talk confidently with service users about mental health problems.

To secure better quality care for parents and children coupled with early intervention, we would need to look at current assessment procedures, eligibility criteria and work differently.

This challenge provoked a lively discussion on the best way to get a family approach . The recent guidance on the Care Programme approach had been very useful in stressing the family but examples from participants of failure to comply with existing guidance dampened optimism of rapid change. The importance of access to advocacy services was illustrated by participants,

who felt strongly that the voice of service users was essential to implementation of change.

Joint commissioning between adults and children's services and protocols requiring record keeping to capture these issues in the assessment phase might be helpful.

Amongst the other issues raised by participants in the discussion at the two workshops run on the day were;

The importance of getting 'the basics right', namely;

- The identification of service users who are parents and children in need whose parents have mental health difficulties and establishing effective procedures for joint evaluation of need, while recognising the possible reticence of some service users who may fear Children's social care involvement.
- Responsive joint commissioning protocols, which actively sought the views of service users
- Possibility that the key agencies more rigorously champion the setting up of local service user steering groups
- Focussing on 'transitions' particularly the question 'when does parenting end?' This issues was raised in relation to the position of parent carers of mentally ill adults

The suggestions were made that;

- 'Serious Untoward Incident Enquiries' should always involve a children's specialist.
- Joint training initiatives should include PCT's
- It is never too early to help children think about mental health issues so the role of schools in 'raising awareness' is likely to be crucial

Sadly some participants felt that the message 'Think Family' was not on the radar of some Mental Health Trust Boards and a degree of compulsion in the forthcoming guidance was essential. There was a special plea for adequately resourced 'Family Rooms' in in-patient facilities to be the norm.

The message that many participants took from the emerging findings of the SCIE/NICE guidance was in relation to the importance of practical assistance to families experiencing parental mental health

Notes from SCIE presentation

SCIE: Who we are

- SCIE was launched in October 2001 as part of the Government's drive to improve social care
- To translate this into guides for policy, practice and service delivery
- To encourage and enable evidence based practice

- To disseminate information and promote good practice

Sources of Knowledge

- Service users, their supporters and carers
- Practitioners and managers
- Research
- Audit and inspection Organisations

Accessing SCIE resources

- SCIE resources are free and available in pdf for downloading or those in hard copy be ordered and delivered free from SCIE
- You can access them:
Social Care Institute for Excellence
Goldings House
2 Hay's Lane, London SE1 2HB

Telephone: +44 (0)20 7089 6840
email: info@scie.org.uk

Context of forthcoming Guidance

“DH will commission the Social Care Institute for Excellence (SCIE) to conduct a systematic review of evidence and existing practice by health and social care services in parenting needs, including meeting the needs of ethnic minority parents; and to publish new guidelines. In developing these guidelines, SCIE will, if appropriate, collaborate with the National Institute for Clinical Excellence” (p105)

Social Exclusion and Mental Health (2004)

Development of the guide

- Reviewed research on impact, prevalence and interventions
- Specifically;
 - the potential direct and indirect impacts of mental illness on parenting, the parent-child relationship and the child.
 - what is known about how many adults who have mental health problems are also parents and how many children in need have parents with mental health problems
 - how good adult and children’s services were at screening, identifying and recording

Reviews of law and policy (context) and of professional education (training)

- Mapped law and policy on issues of parental mental health and child welfare
- Identified whether policy drivers for adults and children’s services helped to think about families as well as their ‘primary clients’

- Evaluated how pre and post-qualifying training for relevant professional groups equips the workforce with the necessary skills to work with individuals and families with parental mental illness

Practice survey – map of existing service responses

- Undertaken in Lewisham, Southwark, North Somerset, Birmingham and Liverpool-
- Explored how existing AMH, C&F and CAMHS services in these areas were delivering services to these individuals and families. It looked at all aspects of service delivery from:
 - Commissioning and planning services,
 - Referral and Assessment
 - Care Planning and Review
 - Workforce Development
 - Information sharing etc. ...

Emerging findings

- Beyond awareness raising
- Tackling social exclusion
- What works
- Creating an evidence base

Emerging findings

- Key findings are interlinked and there is still work to do. Apparent from Law and Policy and practice survey;
- Most 'agencies' are beyond the awareness raising stage and know importance of 'think family' but require guidance on putting this into practice at strategic and operational levels- adopting a 'family perspective'
- Few 'requirements' exist in terms of performance management targets or monitoring criteria to help staff adopt a 'family perspective'. Progress has often relied on goodwill and imagination of people locally
- **Stronger policy directives are required that given 'permission' for agencies and practitioners to move on in this area of work**

Everybody's business

- Achieving change is Everybody's business not just Adult services
- Consideration of Law and Policy evidence suggests a disproportionate emphasis on 'changing adult mental health services' but the evidence suggests that children and family services have equally as far to go in their contribution to improving the life chances of adults and their children – **the guidance should acknowledge this**

Planning and Service Commissioning Structures

- Practice survey indicated - information not routinely collected nationally or locally re. adults with mental health problems who are parents & children who have parents with mental health problems
 - making it difficult for planners and commissioners to prioritise these families locally but
- existing legislation and policy guidance is available to assist agencies with joint planning, joint commissioning and joint funding functions which is not being used
- **So this will need to be addressed in the guidance**

Interagency Protocols

- Widespread inter-agency protocols exist but
 - although time and resources are put into producing them
 - far fewer resources and commitment given to embedding them, diluting their effectiveness

The guidance will address this issue and refer to the SCIE Resource Guide 9 Working together to support disabled parents

Assessment and Care Planning Frameworks

- Assessment and Care Planning Frameworks used by AMH and C&F services are problematic. Although a review of the Care Programme Approach recently has included some improvements .
- The interface between Common Assessment Framework, Integrated Children's System and the Care Programme Approach are crucial areas for further exploration and improvement.
- **There will be specific recommendations about what to do and remember at key stages of the care pathway**

Prevalence and detection

- Evidence from the practice survey was clear that C&F and AMH services need to get much better at identifying and routinely and reliably recording which adults with mental health problems are also parents and which children have parents with mental health problems.
- This information is essential for individual and family planning and can provide important information for planners and commissioners. **This will be addressed in the guidance**

Eligibility criteria

- Eligibility criteria and service thresholds continue to be sighted as barriers to inclusion and in their current form i.e. separate criteria for adult and children that are set very high – work against the identification of cumulative and compounding stressors, risks and opportunities for prevention.
- **This needs to be addressed at operational and strategic levels**

What works

- Little reliable evidence exists re. 'what works' for parents with mental health problems & their children and families.
- Lots of initiatives & developments but not many have been tried, tested or evaluated sufficiently to recommend them strongly
- **The guidance will emphasise the need to generate further evidence about 'what works for families'.**
- Policy, service and practice recommendations in the guide will be 'tried and tested' & their impact evaluated & reviewed.
- The current material provides a base-line measure for further review of the guidance in 3 to 4 years time.

Knowledgeable workforce

- Existing education & training does not sufficiently address the complexities that managers & practitioners have to deal with today
- **Need to be messages to professional bodies & educators regarding the evidence and issues identified in the review**
- **e-learning modules to be developed**

Tackling social exclusion

- Strong theme from all reviews, highlighted by the Social Exclusion Unit Task Force (Think Families) about the need to intervene as early as possible & promote social inclusion.
- Social exclusion levies high costs on families, & wider society, in terms of poor life experiences and future prospects.
- **Requires shift in thinking & action to embrace the importance of preventing ill health and promoting recovery, which guidance intends to signal**

Psycho-social models of intervention

- Psycho- social models are helpful;
- to families in understanding mental illness
- in addressing barriers to inclusion resultant from thresholds which operate separate criteria for adult & children and mitigate against identification of cumulative stressors and risks
- accommodate strengths - based model of intervention, i.e. boosting resilience and reducing stressors in the parent, child, family and environment, **which guidance intends to signal.**

Increased vulnerabilities in some families

Reviews indicated need to;

- **Prioritise assessment of families facing additional barriers to accessing services, who have proved hard for services to support successfully**

- **Families facing multiple disadvantage** which MAY have cumulative & compounding effect e.g. dual diagnosis, domestic violence, poverty, bullying, poor housing
- **Young Carers of parents with mental health problems** - group least likely to be offered carers assessment and services
- **Parents with personality disorder** & their children
- **Families separated** – where child is living in LA care temporarily or longer term
- **Refugee & Asylum Seeking families** particularly those with no recourse to public funds
- Parents with mental health problems **who are also MH or C&F professionals** & their children (Daksha Emson Enquiry & subsequent work)

Development of the guide – next steps

- Synthesis and guide development
- Consultation – December 2008
- Publication – March 2009
- Implementation – funding for 5 implementation sites

Focus & implementation of the guidance

- Purpose of the guidance
- Web and E-Learning resources
- National strategic implementation and evaluation plan
- Implementation sites

Implementation sites

- 5 Implementation sites
- Focus for implementation
- Strengthening the evidence base
- Review

Discussion

- Think family –strategies to make this a reality
- Eligibility criteria and Assessment frameworks- how do they need to change to ensure access to services?
- Early intervention- how can this be achieved?
- What do Adults Services need to do differently?
- What do Children’s services need to do differently?

Consider from the perspective of;

- Joe aged 3, living with a depressed single mother?
- Sarah aged 9, living with a father with OCD
- Tyrone, aged 13, living with a mother with schizophrenia ?

Family Nurse Partnership in England – Early Findings

Kate Billingham – Deputy Chief Nursing Officer, DoH

Notes: Jean Healy

Family Nurse Partnership in England has three aims

1. Promoting the emotional wellbeing of infant and parent
2. Providing an intensive structured family visiting programme
3. Developing transferable learning

The strap line is “Changing the world, one baby at a time”

There is common belief that the system is focused on processes and targets, but focusing on the baby is what the partnership is about. It is a preventive programme for the most vulnerable and parents with low psychological resources. It was developed in America and incoming President Obama has promised its expansion in America.

The most important feature of the programme is that it revolutionises how we work and utilises the expansion in our knowledge of infant development. When talking of children, we don't automatically think of the baby in the womb. Protecting the baby is the intrinsic motivation that the programme seeks to connect with i.e. doing justice to babyhood.

Stress in pregnancy has an impact on outcomes in family work. Targeting the period from early pregnancy to two years is a justified investment of the tax payer's money. Parenting is the most powerful thing that makes us human. The programme therefore needs to be powerful in how this can work – deep within new parents.

How do we support adaptive behaviour change? The key to impact is exploring what users hopes and aspirations and working to achieve them. The programme comes with the approach that enables people to realise their potential and sets clear goals. It builds on strengths and celebrates small steps. It is an information exchange between client and expert involving deep conversations about love and trust, understanding of infant cues and the impact you have on other people.

Water and alka seltzer were used to demonstrate to parents the noise and activity when the mixture overflows. This is compared to noise in the baby's brain which is over stimulated by the goings on around him.

Kate told of a case where a baby was not smiling at his mother. The mother thought he didn't like her, but when the nurse encouraged the mother to play with the child, the mother recognised that what stimulated him to smile at her was when she smiled at him.

One nurse attending family was told to leave, but persisted in going back to the family and the client eventually engaged in the programme. Kate spoke of

the love and courage of that nurse in going back. Engagement is everything and tenacity is important..

The programme showed an impact on smoking in pregnancy and breast feeding.

The sustainability of the programme and building a sound research base was a work in progress. Early evidence was that the programme was deliverable in the UK context and there was evidence of progress in behavioural change.

The involvement of fathers was high and closer involvement of fathers with children was reported.

There were now 20 test sites and a randomised controlled trial was due to start in April 2009. The applicability of the model to a slightly older age group 20-22 was being tested as was its application where staff had to work through an interpreter.

Notes from Presentation: The Family Nurse Partnership

The Family Nurse Partnership is part of the Child Health Promotion Programme

Need, knowledge and evidence for FNP

- Poor outcomes for 2-5% of children with multiple disadvantages
- Evidence of what works
- Advances in neuroscience and infant development
- The need for a powerful intervention to bring about change
- The need for innovation rather than incremental change

"The brain is a social organ that is built through experience."

The Neuroscience of Human Relationships: Cozolino, L 2006

Programme Capitalizes On

- Neuro-genetic systems that promote:
 - Survival
 - Food, Water, Shelter
 - Social Bonding
 - Attachment
 - Protection of Offspring

Family Nurse Partnership Programme

- Preventive, intensive, structured home visiting programme
- Offered to first time mothers under 20 years from early pregnancy until child 2 years

- Thirty years research and development in US showing short and long term benefits, including better antenatal health, child health and development and long term social inclusion
- Testing in England since April 07, now 30 sites and research trial starting April 09

FNP GOALS

Connecting with families to:

- Improve pregnancy outcomes
- Improve child health and development and future school readiness and achievement
- Improve parents' economic self-sufficiency

FNP: supporting behaviour change by:-

- Exploring client's hopes and goals for the future and matching the programme goals with their 'heart's desire'
- Using client strengths and achievements to plan and celebrate small steps.
- Information exchange between client and nurse to help clients understand new concepts (e.g. attachment), discover new language (e.g. love) and understand the impacts of different ways of behaving (e.g. handling conflict).

Testing the FNP in England

- **Wave 1** – 10 test sites Barnsley, Derby, Durham/Darlington, Manchester, Berkshire East, Somerset, SE Essex, Southwark, Tower Hamlets, Walsall
 - formative Evaluation, Birkbeck College, London. First year evaluation published June 2008.
 - 8 sites participating in the RCT
- **Wave 2a** – September 08 – 10 test sites Blackpool, Calderdale, Hastings and Rother, Islington, Milton Keynes, Nottingham, Plymouth, Southampton, Stockport, Stoke on Trent
 - also testing and developing FNP for 20 – 22 year olds, using interpreters, service users involvement.
- **Wave 2b** – April 09 – Cumbria, Cornwall, Coventry, Hull, Lambeth, Leeds, Liverpool, South Birmingham, Northamptonshire, Sunderland.
 - 10 randomised control trial sites

FNP: what we have learnt so far.....

- We can deliver FNP in this country
- The materials work in this country
- It seems to be acceptable to clients
- We seem to be reaching those who benefit most
- Fathers are involved
- The nurses are highly committed
- The clients value their nurses
- The training is highly valued

- Early impacts look promising

But it is difficult work and we have long way to go.....

FINDINGS:

Engagement and level of need

- 87% of those offered the FNP enrolled (1217) (FNP objective 75%)
- 80% without 5 or more A*-C GCSEs
- 78% not employed
- 67% not living with partner
- 75% below poverty line
- 24% report physical abuse in past 12 months, 11% during pregnancy
- 50% BMI < or > recommended range

Indicates simple selection system, under 20 and first time mother will identify appropriate group cf. those in USA trials

Views of clients

- Appreciated difference to other services (non-judgemental, informative, strength-based, paced to suit individual needs, has structure but this also allows for flexibility)
- Did not perceive the offer as pejorative or stigmatising
- Clients identified the nurses, the positive way they talked and responded, as the main strength of the service:

"I was expecting someone to come and treat me like I was thick, because of my age, like I didn't know nothing, but she was quite understanding about it really, you don't get a lot of people like that. She let me ask the questions."

"I thought she was going to be really nosey and look down at me because I'm a teenage mum. But no she was really, really nice. Nothing like I expected her to be. I expected it to be really bad. I get on really well with her".

Father involvement high

- Young fathers show high levels of interest in FNP, and many want to be present for visits or complete the activities
- Out of 7500 visits, father present for 1820 visits
- 49% of clients, father present for at least one visit, most commonly for one to two thirds of visits

"I did not expect to be involved I thought it would be more for my girlfriend's benefit but when I turned up she said she would help me as well. I've learned about being a parent and that's helped a lot. I don't mind doing the worksheets; I find them really useful."

Can FNP make a difference?

- Many clients reported changes in their understanding of pregnancy, labour, delivery and their infant
- Clients had strong recall of the nutritional advice they had received
- Early findings show an impact on smoking in pregnancy and breast feeding

But we need an RCT

Implications of potential impact for the cycle of disadvantage

- Many clients reported planning to return to education
- Closer involvement of fathers with infants
- Clients more confident as parents, doing activities with children likely to enhance cognitive and social development
- Health related changes should enhance child health (e.g. smoking – asthma)
- Feel less judged and excluded, thinking about the future with more optimism, gives them an expectation that formal services could be helpful.

Research activities

- Formative evaluation year 2 in 10 wave 1 sites
- Database development for monitoring the programme delivery
- Small-scale projects exploring FIP delivery, adaptations to FNP in other populations
- Development of tools, assessments and measures to support the implementation of CHPP
- Randomised controlled trial across up to 20 sites (waves 1 and 2b) start April 09 – end Dec 2012

Family Nurse Partnership is work in progress.

The Multisystemic Therapy programme (MST)

Cathy James, CAMHS Regional Development Worker, DoH

Notes: Terry Bamford

The basis for the work was action 20: Early Action on Personality disorder in the Social Exclusion Action Plan. The programme was directed at adolescents on the edge of care.

The underlying premise was that families needed to take back control of children showing antisocial /delinquent behaviour and should be 'empowered' to do so. Its focus was the whole family system using a very structured programme developed in the US.

Despite easy assumptions about parents opting out, nobody wanted their child to go to prison or violent. They want children to grow up as happy, well adjusted adults. But a combination of low parental monitoring, high levels of family conflict, little visible affection, low school involvement and poor academic performance and association with delinquent peers could lead on to involvement with delinquency.

10 pilot sites were testing the effectiveness of the MST approach. A team of therapists and a supervisor worked intensively with a small number of families- usually no more than 6 families per therapist. There was 24/7 availability to the families with intervention usually lasting around 4 months. The intention was that each site would be funded over a four year period with funding tapering in the later years of the programme.

Referrals could come from Children's services, CAMHS or Youth Offending Service from the 11-17 age range of children who were living with their family but at severe risk of getting involved seriously with the criminal justice system.

What made for effective intervention? There needed to be a comprehensive service addressing all the risk factors impacting on the family as a whole. The help given needed to be tailored to meet the needs of the young people and to build on their strengths. And the programme had to be delivered in the natural everyday environment of the young people.

The team worked with the whole family and worked closely with other local agencies eg schools, youth offending teams, social workers. The outcomes sought were better engagement in education and training, reduction in offending or antisocial behaviour, and strengthening family relationships.

So what was the evidence emerging from randomised trials elsewhere? In comparison with control groups, MST had an impact on re-arrest rates, placements away from home and family functioning. A major research programme was to be carried out by University College London to see if these positive results could be replicated in the UK context.

The first new site in Greenwich now had a full caseload and the aim was for all sites to be operational by January 2009. There was therefore a long way to

go to know whether the schemes would work, to test whether other groups of people could be helped if the schemes were effective, and how the schemes could tie in with other developments in policy and practice such as Family Intervention Projects.

The important thing was to continue the focus on improving outcomes for children, families and communities.

Presentation Notes: The Multisystemic Therapy Programme

The National Context -Policy
A cross-government initiative:

Reaching Out: An Action Plan on Social Exclusion

- Early Intervention in Personality Disorder: Action 20
- *'The Government will launch pilots to test different interventions for tackling mental health problems in childhood, such as 'Multi-systemic therapy'.... to prevent the onset of problems later in life.'*

Care Matters: time for change (2007): Funding the development of Multi-systemic Therapy (MST) as an effective specialist intervention for older children and young people on the edge of care

Youth Justice Board are also key partners in the programme

What is 'Multisystemic Therapy'?

- Community-based, family-driven treatment for antisocial/delinquent behavior in young people
- Focus is on "empowering" parents/carers to solve current and future problems
- MST "client" is the entire ecology of the young person - family, peers, school, neighborhood
- Highly structured clinical supervision and quality assurance processes
- Licensed programme developed by Dr Scott Henggler & colleagues

MST Assumptions

- Children's behavior is strongly influenced by their families, friends and communities (and vice versa)
- Families are key to success
- Caregivers/parents want the best for their children and want them to grow to become productive adults
- Families can live successfully without formal, mandated services
- Change can occur quickly
- Science/research provides valuable guidance

Delinquency is a Complex Behavior

- Common findings of 50+ years of research: delinquency and drug use are determined by multiple risk factors:
 - Family (low monitoring, high conflict, etc.)
 - Peer group (law-breaking peers, etc.)

- School (dropout, low achievement, etc.)
- Community (↓ supports, ↑ transiency, etc.)
- Individual (low verbal and social skills, etc.)

The National picture-Practice

Ten new pilot sites of MST have been established as part of a national research programme into effectiveness of the model in England: Barnsley, Greenwich, Hackney, Leeds, Merton & Kingston, Peterborough, Plymouth, Reading, Sheffield & Trafford

- They are building on the experience of the two existing licensed MST sites in England (Cambridgeshire & Brandon Centre in North London) and of programmes in other Northern European countries
- In addition Cambridgeshire are establishing a team to run the MST Child Abuse and Neglect programme

How is MST Implemented?

- Team of 2 to 4 therapists plus a supervisor
- Single therapist working intensively with 4 to 6 families at a time
- 24 hr/ 7 day/ week team availability
- 3 to 5 months is the typical treatment time (4 months on average across cases)
- Work is carried out in the community: home, school, neighborhood, etc.

Partnerships

- Existing, effective joint planning arrangements and programmes across social care, health, education and youth offending services are required to implement the programme
- In addition a partnership with adult services (e.g. mental health, substance misuse), voluntary organisations and housing and leisure services are also key to support the MST programme
- A joint commitment at strategic level to participation in research and the rigours of developing an evidence programme is also crucial

Funding

- Each site will receive funding for four years on a tapered basis
- Funding in year 2 and subsequent years will be dependent on progress of the projects and adherence to the MST model
- Nationally funding is provided from Department for Children Schools and Families, Department of Health & Youth Justice Board

Which Young People?

Referrals could be received from Children's Services, CAMHS or Youth Offending Service

recommend targeting young people who are;

- aged 11 (& in secondary schools) – 17
- have complex and severe emotional or psychological difficulties and/or
 - are displaying severe levels of challenging/anti-social behaviour and/or
 - at risk of entering care or residential EBD school and/or
 - involved in crime and may be at risk of receiving a custodial sentence

- may also be excluded or not attending school
- currently living with family or other carers not in a residential setting

Improving outcomes?

- Teams will offer structured family based interventions and work closely with key relevant local agencies e.g. schools, social workers, Youth Offending Teams
- Interventions will be intensive but of time-limited duration and will be individualised for each young person & family
- Aim will be to impact on all factors (family, school, peer group, community) which influence the young person's behaviour
- Key outcomes are: young person's engagement in education and training, reduction in offending or anti-social behaviour and maintaining young people's family relationships and ability to live in their community

Implications for Effective Intervention

The research on delinquency and drug use suggests that, to be most effective, services should be:

- Comprehensive and have the capacity to address all of the relevant risk factors present for each young person and family
- Individualized to the strengths and needs of each young person and family
- Delivered in the naturally occurring systems and be implemented in 'ecologically valid' ways

MST: Existing evidence base

14 Randomized Trials and 1 Quasi-Experimental Trial Published (>1300 families participating)

- 7 with serious juvenile offenders
- 2 independent randomized trials by Ogden and Timmons-Mitchell
- But need to test if it is the right programme for our communities?

Consistent Outcomes

In Comparison with Control Groups, MST:

- Higher consumer satisfaction
- Decreased long-term rates of rearrest 25% to 70%
- 47% to 64% decreases in long-term rates of days in out-of-home placements
- Improved family relations and functioning
- Increased mainstream school attendance
- Decreased adolescent substance use

National Research

- All sites will be part of a national research programme which will be commissioned by DH/DCSF in England and will be independent of MST services

- A separate tendering process for the research contract has now been completed and the contract is being finalised with a team led by Prof Peter Fonagy at UCL
- The research team will be contacting sites in the next few months to finalise research design & pilot measures
- Full participation in the research is a condition of the funding, researchers will be comparing outcomes of MST interventions against usual local services

National & local progress

- First new site (Greenwich) became operational in July 2008, currently have a full caseload
- 8 out of 10 sites are now operational - aiming for all sites to be operational by January 09
- All sites receive quarterly booster training from MST consultants and a chance to network with other sites
- National research team in place from early 2009

Future Developments

- Lots of unanswered questions and challenges ahead-also opportunities for learning!
- Building and sustaining partnerships: locally, across sites and with families
- Meeting the needs of other groups of young people eg young sexual offenders
- Local and national consideration of how MST work fits with other policy & practice developments e.g. Other family focused services eg FIPs, Care Matters developments, outcome of National CAMHS review
- Maintaining focus on improving outcomes for children, families and communities

Contact

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Question and Answer Session – afternoon

Notes: Terry Bamford

How do we address cultural diversity?

The Family Nurse Partnerships in parts of the USA had worked successfully with non-English speaking families working through interpreters. There were now two pilots taking place in Tower Hamlets and Slough – admittedly very different contexts- to see if this would work in UK. We needed to take slowly and learn. The biological imperative could override some assumptions about parenting.

What was the impact of poverty?

The aim with families was to build on strengths to equip families with resources to invest in time/family. That was why we emphasised what the hearts desire building on the aspirations of young mothers for themselves and their children

Summing Up

Nicky told delegates that the network had written up notes of the day and would be publishing a document which would definitely be available through the website, and after discussion with the steering group, may be available in hard copy. Handouts would be accessible through the website.

Nicky said that it had been a positive day – less about how difficult it is and more about creative ways of working. Thresholds were not barriers and there was teaching for people to either leap over or go under them. There were good protocols and getting other agencies to sign up to say we will deliver a service where families have a child.

Good examples were the Nominated health professionals in FIPS finding ways of getting families over the threshold and into helping services. Kensington and Chelsea joint work showed an example where all services have the confidence to raise questions and encourage ideas where previously they would not have.

There was a clear need to coordinate assessments – need to link up CAF, group assessments, CPA and social care assessments.

How do we fill gaps between and within services, often fragmented at present? There were positive ideas on joint commissioning and inter professional training and education.

We needed to take a lead from what people want from services. People do not see themselves in boxes and we needed to listen to their own accounts of their lives using the FNP idea of building on people's own goals and aspirations allowing children and parents to lead services. This enabled families to actively take control rather than services dictating to them.