

# Presentation & discussion notes

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## Delivering training using Crossing Bridges

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## Presentation notes

### Introduction to Crossing Bridges training programme: key principles

- Uses a broad ecological view of the family.
- Children and their mentally ill parents are better supported and protected if services and interventions are co-ordinated.
- All children and families have a right to services that meet their specific needs.
- Mentally ill adults and their children / families experience multiple disadvantages.
- Agencies need to understand the impact of inequality and actively work with issues of difference.

### Aims of Crossing Bridges

- Raise awareness and promote better understanding and skills.
- Encourage more effective collaboration.
- Encourage analysis of local context, developing better co-ordinated service provision.

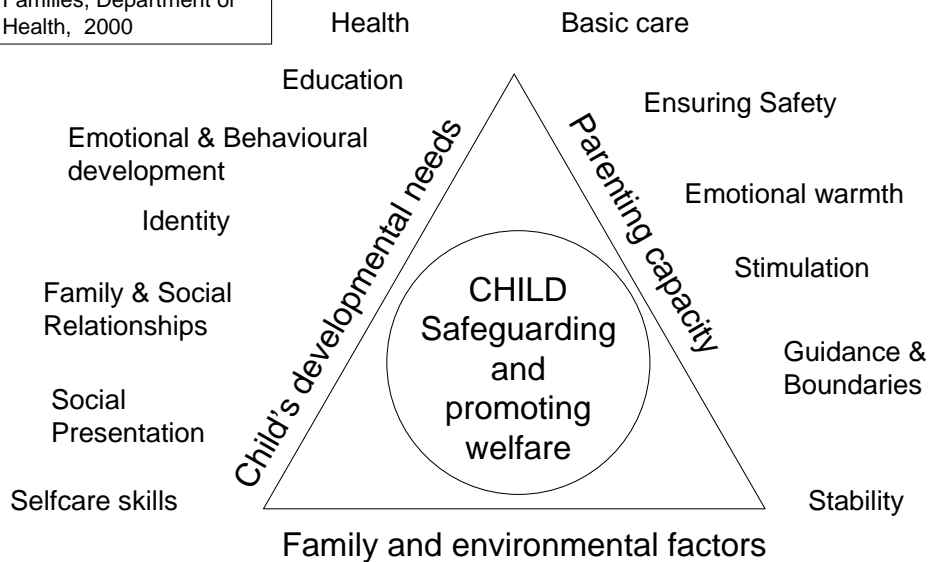
### Mental illness – prevalence

- One in four adults during their lifetime
- 12.6 per cent adult population at any one time
- 40 per cent general practice consultations
- 5,000 suicides and 100,000 attempts per year
- In the UK, 1.7 million adults with mental illness care for 2.5 million children (3.8% of all parents, 30 per cent of mentally ill adults)

### Impact of Mental illness on children and the parenting role

- Parental mental illness will always effect children. It can impact on parenting and the parent-child relationship.
- Parenthood can precipitate and influence mental illness.
- Children's developmental needs and mental health can have an impact on parental mental health.
- Providing physical care is more difficult when mental illness leaves a parent lacking in energy, unable to concentrate or go out.
- Providing a secure emotional environment can be difficult if mental illness impairs the capacity to accept, tolerate and express feelings, or to have empathy and communicate effectively.
- Managing children's behaviour requires emotional control, energy, decisiveness and concentration.

**Reference:** Framework for the Assessment of Children in Need and their Families, Department of Health, 2000



**Interactions and impacts:**

A range of need amongst children of mentally ill parents

<b>A</b> "Well"	<b>B</b> Resilient but in need of support	<b>C</b> Vulnerable and in need of services	<b>D</b> Vulnerable and in need of services and protection	<b>E</b> Child fatalities
<p>————— Increasing needs of children —————▶</p>				
<p>————— Decreasing needs of children —————▶</p>				

The task of effective, collaborative assessment and intervention is to identify and reduce the factors which push the child towards the right of the continuum, and to boost the factors which help the child to move nearer to being truly well.

**Falkov 1996, Review of chapter 8 reports**

- One of the main risks to children whose parents have mental health problems is the failure of adult psychiatric services and child agencies to understand and communicate effectively.

For **themselves**, parents want:

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

For **their children**, parents want:

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

**Children and young people** want:

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

In addition, children and young people taking on a caring role want:

- practical and domestic help
- recognition of their role in the family
- a contact person in the event of a crisis regarding a parent.

*(Reader: Chapter One, page 17 and Chapter Five.)*

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

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

## THE WORKING TOGETHER CONTINUUM

**To what extent is Working Together  
(planning services, assessing individuals  
and families, planning interventions)  
a shared activity?**

Where is/are your agency/agencies  
on this continuum?

Where are individual workers?

Where do you want to be?

How will you get there?

### **Totally separate**

Independent activity, focusing on one client group to the exclusion of others.

### **Lead specialism**

One agency or specialist service 'in charge' of the activity, and dictates what will happen, how and when.

### **One specialism co-ordinates**

One agency or specialist service has a lead role to bring others together.

### **Joint work**

Joint activity, may have different objectives, but overall objectives are agreed.

### **Acknowledgement**

The Working Together Continuum has been developed from a model presented by Glennie, Cruden and Thorn, University of Nottingham and Nottinghamshire ACPC to the 5th National Child Protection Training Conference, Birmingham, 1998.

**Priorities**

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

**Relationships**

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

Change is too difficult in our beleaguered organisations.

There will always be conflicts of interest.

**Resources**

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

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

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

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

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

**Planning**

There's either too many people involved in working with a family or too few. Everything depends on how well individuals get on and work together, not on the system.

Our managers don't provide an overall agreed framework.

**Attitudes**

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

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

It's not my responsibility.

I feel very anxious about this area of work.

**Professional boundaries**

My workers are perfectly capable of doing this work alone.

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

They have no idea what we do.

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

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

**Knowledge**

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

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

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

### Case study: Salma

Salma is a 35-year-old Algerian woman who is seeking asylum in Britain. Her husband died in prison in Algeria. Salma has had no news of her parents and brothers and sisters for some months. Salma is a Muslim. She speaks very little English. Salma and her children have been living in Britain for a year in temporary bed-and-breakfast accommodation. Her children, Samir and Yousuf, are boys of five and seven years old.

Six weeks ago, Salma was admitted to hospital subject to Section 2 of the 1983 *Mental Health Act* for assessment after other residents found her sitting in her room not moving and not speaking. It was not known how long she had been sitting like that, but other residents in the hotel had not seen her for at least two days. Samir and Yousuf were accommodated with African-Caribbean foster carers. After a period of assessment, it is thought that Salma is likely to be suffering from Post-Traumatic Stress Disorder. She has been referred for counselling with an Arabic-speaking counsellor who specialises in work with refugees. Salma is also receiving medication for depression.

It is planned that Salma will resume full care of her children after a further period of recovery. It is unclear how long this will be. At first, the children visited her twice a week in hospital for contact. She now visits them at the foster home three times a week. The foster mother may ask for the children to be moved because she is anxious about Salma's agitated behaviour during the contact visits. She thinks this behaviour is due to Salma's mental illness and she is frightened of this.

Salma is extremely worried about the food the children are being given in the foster home which is not Halal. She fears for them because they are not in a Muslim home environment. She is becoming increasingly frustrated that she cannot get this across to the foster carer or social worker because of her limited English.

#### *Samir and Yousuf*

Samir (who is five) becomes upset when contact visits end, and the foster mother believes this is as a result of Salma's behaviour. Yousuf (who is seven) is highly protective of his younger sibling, and is reluctant to leave him in his classroom at school. He is equally protective of his mother. The children are described as presenting no problems in the foster home, but they are quiet and withdrawn.

The boys have happy memories of their life at home with their parents and family in Algeria. They know it is too painful for their mother to talk about their life before coming to London.

**Crossing Bridges Action Plan:**

<b>Crossing Bridges Action Plan</b>					
Key Questions	Where are we now	Where do we want to be?	How do we get there?	Training issues	Outcomes
<b>Service user perspectives</b>					
Service planning					
Policy					
Organisational issues					
Practice					

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## **Workshop discussion**

This training pack has been available since 1998. It was put together before the introduction of the Framework for the assessment of children in need and their families, but work on the pack was able to take account of the framework's likely content due to steers from the Department of Health.

The pack is not dissonant from the assessment framework. There are plans to revise and update it to take account of the big changes in services.

Kate and Dorian highlighted the way the training pack could be used now and integrated into different training programmes.

They have had both good and poor experiences when using it as trainers. They emphasised that theory of the pack was that you could use different parts of it, depending on the training task, participants and where the organisation is at in its development. They recommended a pick and mix approach to using it.

They pointed out that the process of training in it models the process of clinical practice. Some of its concepts and its ethos are very, very similar to what people do with their clients at ground level.

The pack and the framework is geared towards helping practice and organisations think systematically about families rather than isolating the child. It helps thinking about the impact of children and parents on each other and what that means for the organisation e.g. is there a professional framework for supporting families or does the structure push against it by isolating practitioners in professional specialisms and promoting thinking and working in silos.

They drew attention to Falkov's 1996 finding from his work on child deaths 'one of the main risks to children whose parents have mental health problems is the failure of adult psychiatric services and child agencies to understand and communicate adequately.

A key question to be addressed is: what is good collaborative practice at all levels in organisations? The group agreed that training only front-line practitioners was insufficient to make a significant and lasting difference to agency practice. This fades over time and you need to involve staff at all levels from service planning and management through to the frontline. First line managers and supervisors must be signed up. The beauty of the pack is that you can target it at several different levels, and use a multi-layered approach across organisations. A top down/bottom up approach is recommended and it is key to sign up senior and middle managers. We agreed that signing up staff at the Chief Executive, senior level and operational level is really important, as is identifying the motivators

Training should help all staff to understand the broader context and where they might make interventions. It should integrate service user perspectives and make it clear that poor co-ordination of services makes difficult lives worse. Staff must look at families as a whole and then very specifically at the needs of each family member. Adversity and difficulty including poverty and discrimination can stack up and make families' lives worse.

A strong focus should be maintained on what are the outcomes we are trying to achieve and how do we measure them?

The process of training as well as its outcome is very important. Using two trainers works well and you can then model communication, the different priorities of adult mental health and Children and Family's teams and how disagreements are tackled. Using Crossing Bridges can be a door opener and help workers to see why they are not coping with the dilemmas they face in working with families. It has been found that when adult services workers attend child protection conferences, they can come away feeling attacked and blamed like their clients and see conferences as another burden and not part of the job. Staff need skills to get parents also engaged in the process in a way that does not make them feel blamed.

Training also provides an opportunity to deal with the confidentiality issue and all the misunderstanding and spin accompanying it. One approach is to point out that your adult clients have a right to services to do their parenting job well and you are doing your clients a disservice if you do not share information or give them access to other services. This turns the confidentiality argument on its head as most people want to do their best at work for their clients.

Inpatient mental health workers should not be left out and this can be incorporated into the Mental Health Act and safety training. Get staff to consider why they are not talking to patients about their lives and their worries about the children.

All workers need to be able to think about:

- Who is keeping the whole family in mind when a parent is in hospital?
- Who is talking to the foster carers and the children?
- Who is the link to inpatient ward?
- Who is co-ordinating the care package for the children?

Anyone using the pack needs to think "who am I training?", "what is the organisational and multi-agency strategy", and go through the care pathways, "how do you get in and

out of the system?” and “what are the existing care planning procedures in adults and children” – do they clash and how are cases closed?

Another issue is what we expect of workers and how competent they feel about asking questions and assessing risk. The concept of triage may help here. We may not expect adult workers, including nurses to do a full assessment but we should expect them to do a competent triage and identify children in need. You can also include questions in the CPA docs such as do any of the patients children have a social worker?

Parenting is one of the most difficult tasks for adults but it is also a great motivator. The key is how a parent feels about their children and they do not want to be seen as deficient as parents.

We concluded that there has to be a top down/bottom up approach to training, and that first line managers and supervisors as well as training officers must be involved.

Question for the panel:

How do we ensure that all the new training coming out of the variety of new developments such as the enactment of the Children’s Bill embraces concepts of parental mental illness and how do we ensure the impact of this training is evaluated.