

# The Interfaces Project Report

- Exploring the links between mental health services for children, adults and families

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# FOREWARD

One of the issues that adult mental health workers have struggled with in implementing family work with a Behavioural Family Therapy framework has been the challenge that working with families presents to the established practice of working with individuals. Time and again, workers cite a lack of experience in dealing with families as groups as a major barrier to wider application of the model, and report a lack of confidence in communicating with and engaging children and young people in this type of family work. Within the Meriden Programme, we were concerned for some time that the needs of children whose parents were experiencing mental health problems were being missed.

The Interfaces Project provided an opportunity to examine in some detail the extent to which modern mental health systems are responding to service users as parents, and working in partnership with other agencies and groups who have a role in ensuring children's well-being and healthy emotional development. The well-established Meriden Programme seemed a natural place to host this project because of the infrastructure that had already been established within the West Midlands.

Incorporating surveys, literature review, outcomes from study days and observation of a number of different models of practice locally and beyond, the project generates some challenging recommendations worthy of further discussion and consideration by those responsible for commissioning and providing mental health services, and their partners.

The National Service Framework for Mental Health, the forthcoming National Service Framework for Children, and the recent Green Paper 'Every Child Matters' will go a long way towards providing the policy framework for closer collaboration between mental health services for children and adults, and their partners. The challenge for local services will be to provide effective forums for planning and service development to begin to close gaps across the health and social care system which are still resulting in fragmented services which do not take sufficient account of, or provide holistically for families with mental health needs.

We look forward to using the infrastructure of the Meriden Programme to take forward the recommendations of this report in order to improve services to families where there are children, and where a parent experiences mental health problems.



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# Executive Summary

This project has attempted to explore current practice between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) across the West Midlands. It was conducted under the auspices of the Meriden Programme as a demonstrable piece of work for developing and expanding already established links between AMHS and CAMHS services. The project commenced in October 2002 and was completed in July 2003. Funding for the project was provided by the West Midlands Development Team (now the NIMHE West Midlands Development Centre).

## Data Collection

Data collection was primarily qualitative in nature, although clinicians working in AMHS and clinicians who worked with children were requested to complete questionnaires – thus employing quantitative methods to some degree.

Through this methodology, it was hoped the project would provide insight into current interface practice, including levels of knowledge of clinicians in recognising service users as parents. In addition, it was hoped to elucidate what action was taken, either therapeutically or practically by professionals working in different service settings, to meet the needs of these families. In addition to conducting the surveys, the first author (Tony Gillam) worked within a CAMHS team for 3 months in order to observe practice within this service area, and gain some experience of the practice of CAMHS workers. 'Good practice' areas (nationally) have been visited and highlighted in the report to enable suggestions for improvement to be made and add depth to the data collected locally.

## Main Findings

- A high percentage of AMH workers are aware of service users on their caseload, with whom they are in contact, who are parents.
- Generally, in most AMHS there is currently no way of recording 'parental' status.
- Within AMHS, children of service-users are not routinely assessed or offered any 'planned, purposeful therapeutic intervention', even though there is a wealth of evidence to suggest children can be adversely affected by a parent's mental ill health.
- Those clinicians who offered Behavioural Family Therapy (BFT) to service users were able to assess the needs of the children in a more systematic way.
- BFT appeared to be the only reported therapeutic intervention in AMHS which involved 'whole' families including children.
- When there are concerns about a service user's child, clinicians working in adult services were most likely to liaise with a 'Child and Family Social Worker' and least likely to liaise with a 'Youth Worker'.
- Over a third of those respondents from AMHS did not feel confident in working with children of service users. (It should be noted that all respondents were BFT trained).
- Generally, clinicians perceive that Health and Social Care organisations do not recognise the need for training around working with children.
- The majority of AMHS workers do not have good links with colleagues specialising in working with children and therefore do not work across service boundaries.
- Over half of those surveyed working in children's services suggested that between 25-100% of children with whom they had contact, had a parent with mental ill health.

The majority reported that in children's services there was no formal way of collecting this information.

- All respondents from children's services reported they had contact with parents with mental ill health, with the majority suggesting their work was 'planned, purposeful therapeutic interaction'.
- Children's workers were most likely to liaise with a child's GP, followed closely by the AMHS locally.
- Workers in children's services reported feeling confident in dealing with parents with mental ill health.
- Three quarters of those working with children had links with local services which could help with parents with mental ill health. This included the AMHS but not exclusively so.
- Just under half of those surveyed suggested that the children with whom they have contact, who are from families where a parent has mental ill health, will 'most likely' continue to have mental health difficulties themselves into childhood.
- Transition between CAMHS and AMHS services was seen as 'difficult' by over 90% of respondents working in children's services.

## **Conclusion**

- There is evidence of much good practice taking place both within and outside the West Midlands which should be endorsed and built upon.
- The profile of the needs of children whose parents have mental health problems is relatively low and no strategic plans are in place to address this.
- For AMHS workers, BFT seems to be a way of involving children in 'purposeful intervention' and beginning to assess the impact of the parent's mental ill health on them.
- Strict entry criteria and service boundaries do not allow practitioners to feel able to collaborate or undertake joint-working arrangements across service settings. This prohibits a good effective service being delivered to parents and their children i.e. families.
- There is significant evidence to suggest that children living within a family where a parent has mental ill health could be adversely affected and services are clearly not routinely identifying, assessing or meeting this need.
- Practitioners, particularly those working in AMHS, do not feel they have the skills to involve these children in any meaningful intervention even though they are in contact with the parent.
- Liaison between services is patchy and more likely to be triggered by those working with children.
- The majority of AMHS have no formal way of collating information about service users as parents, which given the high percentage of hospital admissions who are parents (particularly mothers), is a failure to address the needs of the user and their children.
- Workers in children's services are more likely to adopt 'family sensitive' (i.e. serving whole family) practices than their colleagues in AMHS.
- Although children's workers feel more confident in working with parents with mental ill health than their colleagues, the majority still highlight the need for training in this area.

## **Suggestions/Recommendations**

### **Working with families**

Organisations should provide truly 'family orientated' services. Models of working should not be constrained to particular service settings and both systemic and psychoeducational models of family work should become more widespread amongst practitioners.

### **Team Leadership**

Good team leadership should be aspired to in terms of different professionals working together and managed by a single team leader.

### **Therapeutic Setting**

Consideration should be given to the most appropriate venue for intervening with families.

### **Interagency Working**

Statutory services need to address the issues of service boundaries and develop practices or protocols to enable much more collaboration to take place between CAMHS & AMHS. In addition these services can learn from the non-statutory, youth and education services.

### **Staff Development**

Training is identified as a key area for both adult and children's workers. There appears to be a substantial unmet need for training – in particular joint training in this area. This needs serious consideration in order for workers to feel equipped to meet the needs of these families.

### **Invisibility**

The needs of children with a parent with mental ill health should be routinely recorded by AMHS. In addition, all professionals and services coming into contact with these families should share the task collaboratively in order to fully address the issues involved. This may not ultimately effect capacity but begin to change the culture of mental health service provision to routinely involving families.

**Marie Crofts  
Project Worker  
The Meriden Programme**

## **Background to ‘Interfaces Project’ and project aims**

This project was borne out of growing enthusiasm, interest and frustration in interface and liaison between CAMHS and AMHS and other allied services in the West Midlands.

Through a number of events and consultation meetings with people working in these settings, it became evident that it would be useful to understand current interface practice in order to identify and explore in what ways the experience for users of mental health services and their families could be improved with particular reference to parental mental ill-health and its effects on children. Clinicians often reported feeling frustrated by service boundaries and understanding from colleagues working in other service settings.

Following an event in March 2002, which pulled together representation from most geographical areas within the West Midlands, the consensus was to attempt to establish a baseline of service provision in one locality, and to map current activity across the rest of the West Midlands to enable suggestions or recommendations to be made to improve and develop current practice and service provision.

The project aimed to produce:

- a) A service mapping of current interface practice by AMH workers.
- b) A service mapping of current interface practice by CAMH workers and selected other children’s workers.
- c) An in-depth assessment of current practice within Worcestershire (area from which Project Worker, Tony Gillam, was seconded).
- d) A detailed literature review to enhance and inform current practice in all service settings.
- e) The development of suggestions/recommendations for improving effective interface and liaison between services.
- f) A selected tour of good practice both within and outside the West Midlands.
- g) Networking opportunities through events disseminating and sharing practice across the West Midlands.

The project was funded by the former West Midlands Development Team (now NIMHE West Midlands Development Centre), under the auspices and lead of Keren Corbett, CAMHS/EI Lead.



# Chapter 1

## The Interfaces Project: Introduction

# The Interfaces Project

## Introduction

The Interfaces Project was managed within Meriden - the West Midlands Family Interventions Programme. The central concern of the Interfaces Project is parental mental health and the impact this has on children. It seeks to approach this by exploring the interface between child and adolescent mental health services (commonly abbreviated to CAMHS) and adult mental health services (here referred to as AMHS). The project's overarching aim is to understand the current interface between CAMHS and AMHS, across the West Midlands, where a parent has a serious mental health problem, or where there is evidence of emerging psychosis in young people, and to inform future service development.

The first author (Tony Gillam) was recruited to undertake the bulk of the project work with guidance from staff from the Meriden team and the Regional CAMHS Lead. At the start of the project, Tony was a mental health nurse with no previous experience in CAMHS, but 12 years experience as an AMHS Community Psychiatric Nurse (CPN). He is also a trainer in the Meriden Programme and coordinated psychoeducational family interventions training in the Wyre Forest locality of Worcestershire. The project took place over a 9-month period from October 2002 to July 2003.

## Parental mental health

Parental mental health in the literature or in this context refers to people with mental health problems who are also parents of dependent children. Inevitably this implies a consideration of the mental health and general welfare of the children of these parents, and the relationship between parental mental health and child mental health. This invites an examination of the interfaces between services (including non-statutory and other community agencies) for families, adults and children. Of particular interest are the interfaces between adult mental health services (AMHS) and child and adolescent mental health services (CAMHS). There are, then, three overlapping areas of interest:

- The relationship between parental mental health and child mental health.
- The interfaces between services for families, adults and children.
- In particular, the interface between AMHS and CAMHS.

It becomes clear that to speak of 'focusing' on such a divergent area of interest is something of a paradox. To further complicate matters by adding to this already 'divergent focus', consideration must be given to the concept of 'early intervention'. This term has different meanings depending on context. For a primary mental health worker, it can mean intervening with parents in the early years of a child's life to promote positive parenting, thus preventing the development of behavioural or mental health problems in the child in its later life. For an adult psychiatrist, it can mean intervening early in the prodromal stages of a psychotic disorder in order to improve outcomes for that individual. Both interpretations are central to this piece of work for two reasons. First, interventions with children and young people are more likely to promote positive mental health and prevent the development of mental health problems because of the continuities between child and adult mental health. Second, early intervention in psychosis necessitates services which attempt

to bridge the gaps between CAMHS and AMHS, (not to mention the gaps between primary and secondary care and those between health, education, social services, substance misuse services, youth services and youth offending services).

### **The link with Meriden**

The Meriden Family Interventions Programme was one of several initiatives launched in the West Midlands Region in 1997 and 1998 aimed at promoting evidence-based healthcare. The overall aim of the programme is to train staff in all of the Mental Health Trusts (and Primary Care Trusts that provide mental health services) in the West Midlands region to be able to work with families using a behavioural family therapy (BFT) approach, thereby ensuring that families across the West Midlands receive the help they need. The two key aspects to the programme are:

1. A cascade system of training whereby a number of therapists in each of the Trusts are trained as trainers so they, in turn, can train and supervise further therapists within their own Trusts;
2. On-going contact with management and trainers in Trusts to support and maintain successful implementation of family work.

Renewed funding was made available for the Meriden Programme after its initial three years, conditional upon the programme continuing to train further therapists and trainers, and addressing seven key target areas:

1. Liaison with child and adolescent services.
2. Development of family work in in-patient services.
3. Liaison with primary care.
4. Ensuring the integration of family work in undergraduate curricula.
5. Ensuring that family work is embedded in services.
6. Greater involvement of carers and service users both in training and delivery of family work.
7. Addressing issues relating to family work and cultural diversity.

The majority of Meriden trainees work in AMHS. For many of these workers, involving families and carers, and certainly the concept of working with families in a purposeful way (as exemplified by BFT), was viewed as a shift from the predominant approach of treating individuals. By contrast, workers in CAMHS tended routinely to work with families and often used a family therapy approach, albeit a different model.

### **Crossing Bridges**

*Crossing Bridges* (the Department of Health-sponsored training resource for working with mentally ill parents and their children) highlights “the strong association between parental mental illness and difficulties in the development and psychosocial adaptation of their children” (Falkov, 1998: 7) but also recognises that “not all children whose parents are mentally ill will inevitably experience difficulties” (ibid.). Falkov points out that, despite a growing body of evidence about the links between the problems of mentally ill parents and their children, there has been a failure to integrate research findings into practice:

A disparity exists, therefore, between the extensive identification of emotional and behavioural problems in children, and a scarcity of initiatives in service development

and training to address needs of *both* mentally ill parents and their children, especially in relation to parental mental illness and its impact on childcare, parenting, significant harm and maltreatment.

(*ibid.*).

This disparity may in part be due to traditional barriers between services for, on the one hand, mentally ill adults (who may be parents) and, on the other hand, children with mental health problems (who may be the children of adults with mental health problems). Reder *et al.* (1998) identify three related factors which have traditionally emphasised the differences between age groups rather than their inter-relationship and which, they argue, have thereby acted as barriers to mental health professionals working across the child-adult interfaces. These are:

- The theories and knowledge bases which have dominated the specialities.
- The organisational structure of services.
- The ways that professionals are trained.

As a result of these, according to Reder *et al.*, the different histories of AMHS and CAMHS “reveal parallel, rather than integrated, developments” (Reder *et al.*, 1998: 5).

# Chapter 2

## Literature Review

# Literature Review

## Growing interest in child/adult interfaces

It may seem remarkable that interest in parental mental health did not gather momentum until the last few years of the 20<sup>th</sup> century. For example, 1998 saw the publication of *Crossing Bridges* (Falkov, 1998) – the same year that a conference was held in London called *Interfaces between Child and Adult Mental Health*. The conference led to the publication of Reder *et al.*'s book *Family Matters* (2000) which explains the interest in the interfaces derived from growing public and governmental concern for children. The “momentum generated in clinical and academic circles has been maintained by concerns about child abuse and adolescents’ problems which have gained public attention and become priorities for central government” (ibid.: 12).

The Children Act (1989) provides the key legislative base for childcare work. This Act introduced the concept of ‘significant harm’ to describe the impact of adverse experiences on children, requiring all professionals (including those primarily involved with adults) to attend to the quality of parental care. One consequence of the Act has been the growing interest in the development of parenting skills programmes, since it emphasises that parents’ potential to change as the result of interventions should be assessed.

Concern was also growing, after an examination of case reports submitted to the Department of Health, demonstrated an association between parental mental health problems and severe and fatal abuse. This link was confirmed by Falkov (1996) in a report pre-dating *Crossing Bridges*. The impetus for growing interest in Child/Adult interfaces can be seen as arising primarily from concern about the risk to children rather than from any concern for the well being of parents with mental health problems.

## The influence of community care

The advent of community care in mental health has changed the landscape of parental mental health considerably. The number of children born to parents with schizophrenia doubled from 1935 to 1955 and while the conception rate for adults with schizophrenia or depression is now believed to be close to that of the general population (Falkov, 1998). From an Australian perspective, Bassett *et al.* write that:

Until recently, people with a mental illness rarely had children and if they did, authorities removing those children easily resolved the difficulty. While this solved the problem for those in control, it left in its wake an extreme amount of psychological and emotional anguish for the parent. The system treating these people did not acknowledge the possibility that they could parent successfully. However, with the advent of new medications and a shift from the medical model of practice to a psychosocial basis of practice, people with a mental illness are assuming the parenting role.

(Bassett *et al.* 1999: 597-8)

Alongside concerns for the welfare of children, then, the growing interest in parental mental health (and reconsideration of the historical separation of CAMHS and AMHS) can be seen in the context of changing concepts of treatment and good practice as a result of advances

in community care. Hadley and Clough (1996) cite five themes of importance in the rise of community care:

- Advances in drug therapies from the 1950s (which made community treatment of people with mental health problems possible).
- Normalisation or social role valorisation (an approach which stresses equal access to services).
- Integration (the notion that, as far as possible, people should be able to live their lives in mainstream society, despite particular problems).
- Choice (service users should have maximum choice with professionals having less influence).
- Living in one's home whenever possible and in home-like situations where it is not possible to live unsupported (something affecting older people, children, people with disabilities and people with mental health problems).

Furthermore, the drive for de-institutionalisation, from the 1960s onwards, resulted in plans to reduce the numbers of mentally ill people living permanently in long-stay hospitals and the eventual closure of many of these institutions. "This," write Hadley and Clough, "could only be achieved successfully in the general shift to home living through the parallel strengthening of health and social services in the community" (Hadley and Clough, 1996: 11). They argue that, in the 1980s and 1990s this strengthening of community services was neglected. Thus, contemporary commentators John Mahoney and Antony Sheehan (Joint Heads of Mental Health at the Department of Health of the present-day government) are able to quip: "People say community care has failed. We say it has never been tried" (Laurance, 2003: 3).

Whether or not community care has ever been properly implemented over the past half-century, Falkov (1998) stresses that the clear consequence of this model for parental mental health is that "mentally ill parents and their dependent children will be spending more time together" which "creates the dual burden of increased childcare responsibilities for parents and greater exposure of children to problematic parental symptoms and behaviours when they arise" (Falkov, 1998: 7-8). Moreover, since parents with mental health problems are nowadays less likely to be hospitalised in long-term facilities, the problem of their repeated hospitalisation with its potential to disrupt seriously child care and family life is now a major consideration (ibid.).

### **Caretaker children - the child's perspective of parental mental health**

Reder and Lucey (2000) point out the positive benefits to parents of their children's behaviour:

Some depressed parents regard their children as the only reason to keep going and, although this places an immense burden on the child from which they need to be freed, it can provide a route in to treatment that might not otherwise be effective.  
(Reder and Lucey, 2000: 63).

Often children take on the role of caretaker to their parent. According to one estimate there may be as many as 10,000 young carers of a mentally ill parent in the UK (Edwards and Smith, 1997). While a child's support for their ill parent can help stabilise the parent's condition and may even help the child's sense of fulfilment and self-esteem, the concerning aspect of

this role reversal is the sacrifice of childhood entitlements, a sense of burden and the age-inappropriate assuming of a parental role (Reder and Lucey, 2000).

Falkov (1998) outlines the long-term impact of burdensome early caring experiences which include:

- The development of premature self-reliance with difficulties in adulthood asking for help, relying on others, and developing trust and intimacy in relationships.
- The emergence of symptoms requiring treatment, grief over loss of a balanced childhood, and diminished quality of life.
- The effects of earlier experiences making care giving in adult life (for the elderly parent or the transition to parenthood) too daunting.

“These difficulties” writes Falkov, “highlight the lifelong implications of mental illness in families and provide further evidence for the importance of support for children and young carers as part of a longer-term preventive strategy” (Falkov, 1998: 18).

Recent guidance from the Department of Health underlines the evidence to suggest that people with mental health problems supported by a young carer are less likely to be receiving treatment and support in their own right, compared to people supported by adult carers. This, of course, means that young carers themselves are less likely to receive help than adult carers. The guidance goes on to recommend that, where assistance is provided to young carers:

‘It needs to avoid, however, unintentionally, reinforcing the role of the child or the young person as a carer. Interventions to help support the family as a whole and promote the parenting role of adults are more likely to be helpful and ensure that a child’s welfare or development is not impaired’

(Department of Health, 2002: 20).

### **Effects of major mental disorder on parents and their parenting**

Duncan and Reder (2000) review the effects of major psychiatric disorders on parents and their ability to provide adequate parenting. First, they point out that, in order to appreciate the impact of these disorders in parents on their children, it is necessary to consider what are the basic needs of children which those taking care of them must meet, and then to consider what is ‘good-enough’ parenting. Some of these needs and responsibilities will vary from one culture to another. Duncan and Reder “summarise the components that are commonly agreed for western cultures” (ibid: 85), although it could be argued that this, in itself, may not be politically neutral (see Table 1).

Duncan and Reder go on to consider the major psychiatric disorders of depression and schizophrenia, conditions which have certain common features. Both have a genetic component and are characterised by recurrent episodes precipitated by stress. Episodes can affect individuals’ ability to live independently, and their thoughts, feelings and behaviour may be changed profoundly. While this is distressing enough for individuals with mental health problems and other adults close to them, the symptoms of major mental illness intrude directly into the individual’s parenting role. For example, increased irritability, unresponsiveness, critical attitudes and impaired decision-making impact on parent-child communication, leading to vicious circles where parenting becomes less effective, parents



feel a sense of failure, their self-esteem and optimism diminish, parenting becomes still less effective, and so on (ibid.)

*Table 1.* Essential needs of children that must be satisfied by ‘good-enough’ parenting (Reproduced with kind permission from the publishers, Routledge, from Duncan and Reder, 2000: 85)

<i>Physical needs</i>	<i>Behavioural needs</i>	<i>Emotional needs</i>
Nutrition	Stimulation/interaction	Affection/empathy
Warmth/shelter	Exploration/learning	Availability
Health/cleanliness	Socialisation/role model	Consistency
Safety	Limit-setting	Reality testing
Contact/comfort	Rest	Building of self-esteem
		Attachment/autonomy
		Individual identity
		Advocacy

Most of the literature on the effects of mental ill health on parenting examines depression, in particular, maternal depression. For example, Pound (1996) makes this rather bleak but accurate summary based on an overview of the literature:

Children of depressed parents, and particularly depressed mothers, are at high risk of developing psychiatric disorder either currently or in the future, have poor interpersonal skills and few friends, and suffer either from dysfunctional levels of guilt, poor self esteem and clinical depression or from detachment, aggression and conduct disorder. Cognitive impairments and attention deficits interfere with learning skills such as reading.

(Pound, 1996: 209)

The literature that exists on the impact of parental psychosis tends to focus on the genetic contribution. These studies show that children of parents with psychosis have significantly more psychopathological diagnoses than do controls (Landau *et al.*, 1972, Schachnow, 1987). Aldridge and Stuart (1988) reported on a befriending project for children of parents with schizophrenia in Leeds. They found 73 per cent of the children were significantly affected by their parent’s illness, the main issues they reported being:

- A sense of being ignored.
- A pressure to be good.
- False maturity.
- Fear of family separation.

In Landau’s (1972) study, children of parents with psychosis showed a significant increase in the following:

- Delay in speech development and toilet training.
- Enuresis.
- Eating and sleeping problems.
- Undisciplined and aggressive behaviour.
- Difficulties relating to peers.
- Psychosomatic complaints.

- Anxiety.
- Depressive tendencies.
- Insecurity.
- Obsessive symptoms which they relate to the daily stress of having to adapt to their parent's bizarre behaviour and thoughts and not having someone with whom to identify. (Landau *et al.*, 1972).

It is interesting to relate this last point, if not all of those listed, to the *Essential needs of children that must be satisfied by 'good-enough' parenting* mentioned in Table 1, though it should certainly not be inferred that parents with psychosis are incapable of providing 'good-enough' parenting. Especially between episodes, many people with psychosis parent their children well (and, of course, conversely it should be said that many parents without the burden of a major mental disorder do not provide 'good-enough' parenting). Rutter and Quinton (1984) in a four year follow-up study of children of parents with mental health problems, found that one-third showed no emotional or behavioural disturbance, one third showed transient problems and one third persistent disorders.

### **The experience and feelings of parents with mental health problems**

While most of the literature is preoccupied with the potential for psychopathology in the children of mentally ill parents, there is a dearth of literature on the experience and feelings of these parents. One rare example is Sands' (1995) comparison of the experiences of low-income single mothers with a mental illness with the experiences of low income single women without an identified mental illness. Sands found that:

- Motherhood was central to the parent's existence, giving it meaning and focus.
- There was a desire for normality. The parents wished to develop a normal life for themselves and their children.
- Staff involved with the parents who had a mental illness recognised the need for guidance and direction to be given though the mothers themselves did not acknowledge this.

In Bassett *et al.*'s (1999) Australian study, the major themes that emerged for the parents with mental health problems were:

- Fear of losing 'residency' (i.e. custody).
- The trauma of hospitalization.
- Social isolation.
- Care of the child if the mother becomes ill.
- Accessing community resources.
- The stigma of mental illness.
- Dissatisfaction with mental health services.
- The importance of their relationship with their children.

Another concern was the fear parents with mental health problems held that their children would develop mental health difficulties themselves. It seems likely that this is a concern for parents, children and siblings alike. Indeed Engquist (1998) found that younger siblings expressed worries about acquiring the illness of their older siblings, while it is probable family members have some awareness of genetics as a contributing factor in psychosis.

The most significant difference between single parents with and without a mental illness in Bassett *et al.*'s (1999) study centres around the issue of maintaining 'residency' (the term now used in Australia for 'custody'), or of regaining residency of their children when it is lost. Parents with mental health problems felt inhibited in discussing areas of concern, and greatly feared authority stepping in and removing the children.

### **Effects of parental schizophrenia and depression on children**

With regard to parents affected by either schizophrenia or depression, Rutter and Quinton's (1984) study found that the effects on the child were independent of the parent's diagnosis and related more to the psychosocial consequences of their problems, most notably hostility and marital disharmony. Duncan and Reder (2000) therefore propose that "the most useful way to consider how children experience their parent's mental health problem is to focus on the impact of the parental *behaviour* rather than their *diagnosis*." (ibid. 87-8). This fits well with the behavioural family therapy approach, which emphasises positive changes in behaviour to manage stress, rather than individual or family pathology.

### **'Invisible' children**

Fredman and Fuggle (2000) explored the involvement of children in family work when their parent presents with mental health problems. They argue that family approaches to adult mental health problems commonly focus on the adult 'symptom bearer' or 'identified patient', so that the other family members are considered only in terms of their contribution to the persistence and management of the 'patient's' symptoms. They take as an example the research showing that people with schizophrenia living with families characterised by high expressed emotion had higher rates of relapse (Leff and Vaughn, 1985). This led to the development of psychoeducational family interventions which sought to empower families to maintain a calm emotional atmosphere (Falloon *et al.*, 1985). However, "the way that children participated in this endeavour," say Fredman and Fuggle, "was generally unspecified." Part of the explanation for this may lie in the fact that, in most of these studies, the children were already adults.

The lack of detail about how children participated in family interventions is not a criticism of psychoeducational approaches only, since different models of family therapy also tend to overlook the participation of children. For instance, where the whole family is construed as 'the patient', or where the problem has been seen not as a psychopathological condition of the individual but as an indication of family communication problems, although children have been included in the systemic formulation and therapeutic tasks, "the adult has generally remained the focus of concern and the problem is rarely formulated in terms of the needs, language or experience of the child" (Fredman and Fuggle, 2000: 214).

Fredman and Fuggle rightly criticise the outcome research of family therapy which traditionally evaluates efficacy of family treatments in terms of improvement in the diagnosed family member and/or systemic or relationship change in the family as a whole rather than paying attention to the affected child members. This focus has, they claim, "distracted family therapy practitioners and researchers from also attending to the consequences of the symptoms for the affected individuals, in particular children, in the family" (ibid).

There is extensive evidence for the efficacy of psychoeducational family interventions for the treatment of schizophrenia (Mari *et al.*, 1997). There is also good evidence for the

efficacy of family therapy for the treatment of childhood disorders (Pinsof and Wynne, 1995). However, as Fredman and Fuggle complain, it is more difficult to find accounts of family work designed specifically with a focus on the well-being of the child(ren) in the family affected by an adult's mental health problems (Fredman and Fuggle, 2000). They cite Engquist (1998) who reported on the lack of involvement of younger children in the treatment of older, often adult, siblings with a psychiatric illness. Engquist highlights the failure to invite these children to meetings to discuss the sibling's psychosis and a long delay in giving information. All the affected siblings stated they would have liked the opportunity to talk with someone to make sense of their sibling's behaviour, to relieve feelings of loneliness and to discuss their concerns about acquiring the illness themselves and their worries about their friends finding out (ibid.).

In the case of parental depression, Garley *et al.* (1997) suggest that:

If it is indeed true that children attribute depression to internal causes, then hope for the parent or situation to improve, fear of developing the disorder themselves, and uncertainty for the future become central issues to explore with these children.

Garley *et al.* (1997: 98)

### **Making sense of illness experiences through the use of stories**

"A narrative or story," write Fredman and Fuggle, "offers a way of holding together complex and possibly ambiguous, contradictory or conflicted experiences within a connected pattern of meaning" (Fredman and Fuggle, 2000: 215). They describe how they used narrative and stories within the context of family therapy which took the affected child as its focus in a family where parents or adult siblings had mental health problems. The author has written elsewhere of how stories and story-telling can be helpful in mental health work (Gillam, 2002), and Fredman and Fuggle cite Bruner (1990) who argued that children produce and comprehend stories, are comforted and alarmed by them long before they are able to express simple logic with language.

Lloyd (1998) has also made use of story-telling in her booklets for children, one of which (*Children have feelings*) was published as an appendix to *Crossing Bridges* (Falkov, 1998). Lloyd's illustrated stories use the characters of Harriet Hamster and Ashley Brown Mouse to help affected children come to terms with their own feelings when a parent or main carer is unwell with mental ill health.

Lloyd's stories address many of the issues discussed hitherto in this literature review. Importantly, they stress that the child is not to blame for the illness since guilt is a common feature (Pound, 1996), they attempt to reduce the child's anxiety (Landau *et al.*, 1972), they empathise with feelings of anger, fear, sadness and loneliness (Engquist, 1998) and encourage the expression of feelings, they confront the fear of separation and family break up through hospitalisation (Falkov, 1998) but offer reassurance that people recover from mental illness, they are written in a language understandable to children (Fredman and Fuggle, 2000) and focus on parental *behaviour* rather than *diagnosis* (Duncan and Reder, 2000).

### **Parental mental health and the Interfaces Project**

This review began by stating that the central concern of the Interfaces Project is parental mental health and the impact this has on children. Having explored this in some depth, it is

now time to approach the subject somewhat obliquely by exploring the interface between CAMHS and AMHS, since it is the interface between these services which ultimately affects agencies' multifarious responses to the phenomenon of parental mental health.

### **The growth of liaison between CAMHS and AMHS**

Alongside the growth in community care, the movement for de-institutionalisation, the growing concern for children's welfare enshrined in The Children Act 1989 and the increase in the numbers of mentally ill people becoming parents, there have been other changes which have led to a greater rapprochement between services for adult and child mental health care. Maitra and Jolley (2000) mention a resurgence of interest in a psychosocial approach to mental health problems and the requirement of the Care Programme Approach (introduced in 1991) that adult services address a broader range of both clinical and social functioning. Complementary to the movement in adult services is what they see as the gradual reintegration of the three main streams of interest in the field of child mental health:

- The psychiatric.
- The psychoanalytic.
- The developmental/educational.

"The growth" they argue, "of newer disciplines (such as family therapy) has led to increasing interdisciplinary dialogue, widening the focus in contemporary child mental health teams to include the biomedical, interpersonal and social contributors to childhood disorder" (Maitra and Jolley, 2000: 289). Perhaps over-optimistically and with some mixing of metaphors, they believe that the apparent distance between CAMHS and AMHS has begun to break down (sic) and a dialogue is taking place based on a common language and a shared biopsychosocial model.

Far from speaking a common language, many might argue that one of the obstacles to CAMHS/AMHS liaison is the different terminology used by the two groups. Macdonald (2002) uses an entire article to explain what is meant, for example, by Tiers 1, 2, 3 and 4, and what the difference is between Primary Child and Adolescent Mental Health Workers (PCAMHWs) and Primary Care Mental Health Workers (PCMHWs). (See Glossary for an explanation of these terms). No doubt CAMHS workers might similarly struggle to appreciate the difference between "the care management approach" and "the care programme approach", or to understand what AMHS workers mean by "standard and enhanced CPA" which is, of course, a simplification of the previous tiered system of Care Programme Approach! (Department of Health, 2001).

Apart from linguistic differences, there are other potential obstacles to liaison. Maitra and Jolley (2000) mention the ethical dilemmas for AMHS workers whose patients (or their relatives) confide their concerns for the welfare of their children in the expectation that these will remain confidential. AMHS staff can be concerned that sharing their worries about these children with other agencies will be viewed as a breach of confidentiality which may alienate the patient, precipitate default from treatment and thus further destabilise the home situation.

Where risks are clear (e.g. where a patient with a history of violence expresses murderous impulses towards his children) the duty to take seriously the immediate risks to the children outweighs the risk of losing the patient to treatment. The professional has a clear duty under The Children Act 1989 which states that the child's welfare is paramount. Thus, in

day-to-day practice, where adults have competing interests, the welfare of the child takes precedence over the welfare of the adult (Children Act, 1989). Maitra and Jolley recognise, though, that such clear-cut cases are rare and that it is more likely that AMHS workers will find themselves in more of an ethical 'grey area' in which they must decide whether their professional responsibility to consider the safety of children overrides their responsibility to maintain patient confidentiality. This is certainly an area of potential conflict between AMHS and CAMHS, and particularly between AMHS and Area Child Protection Committees. It is acknowledged that:

There is an inevitable tendency for adult services to be focused primarily on the therapeutic objectives for their adult patients, and the perceived need to maintain a therapeutic relationship with the patient may be an impediment to the full consideration of children in such circumstances.

(Maitra and Jolley, 2000: 297)

Ethical considerations and conflicts apart, Maitra and Jolley found, in the early stages of their liaison work, that adult workers were anxious that attempts were being made to recruit them as co-therapists on a routine basis in formal interventions for their patients' children (ibid). CAMHS workers expressed similar concerns that liaison would give rise to an increase in co-working which would mean, in practice, an increase in workload. It was recognised, however that greater resources might be needed in both services to facilitate more direct joint work (ibid.). Of course, if AMHS workers were routinely offering family interventions then they would find themselves routinely supporting their patients' children at the same time as providing an intervention to their patients. Similarly, CAMHS workers could - as some already do - work with parents with mental health problems as part of the intervention they offer to children and adolescents. Thus, extra resources would not necessarily be required in either service.

Maitra and Jolley concluded that inter-agency collaboration is no more than the tip of an iceberg which could include regular joint working, prophylactic interventions for children and the involvement of adult workers in family interventions. Ultimately, they suggest what is really required is a master strategy for 'culture change' in mental health and social services along with, among other recommendations, the merging of multiple funding streams to attach money and services to families rather than to the continued separation of adults and children; respite care for children of mentally ill parents; and for children's services to explore closer collaboration with adult-focused mental health services (ibid.).

### **Recommendations for research, practice and service development**

Reder *et al.* (2000) discuss whether a revolution in theory and practice is necessary for practitioners to recognise interface issues, but conclude that incremental change is more appropriate. Although Maitra and Jolley (2000: 299) support the idea of "a master strategy of 'culture change'" Reder *et al.* believe that "a few small changes may be all that is necessary to benefit a number of children and parents whose problems are interacting, and these differences may in turn initiate a process that widens the scope of help available to many more" (Reder *et al.*, 2000: 318).

One suggestion for a small step which may ultimately produce widespread change is the creation of history sheets that prompt the practitioner to compile a genogram (family tree), include the ages of the adult service user's children and consider whether there are any

concerns about the children's welfare (ibid.). (In fact the Care Programme Approach, which is supposed to be used as a matter of course in adult mental health, should prompt the practitioner to consider the existence – if not also the welfare – of patients' children).

Reder *et al.* go on to consider a longer-term strategy for addressing the interfaces, four aspects of which will be considered in detail here:

- a) Liaison.
- b) Consolidation of specialised services.
- c) Research.
- d) Training initiatives.

### **a) Liaison**

Liaison initiatives between CAMHS teams and AMHS in the community and hospitals is seen by Reder *et al.* as crucial. Alongside this, they highlight liaison between adolescent and substance misuse services and between mental health and perinatal services. They suggest such initiatives could begin in small ways through personal contacts and arrangements for consultation and cross-referral, identifying specific liaison staff within respective teams, in a way similar to the existing system of Named Professionals for Child Protection. Under this system a professional with recognised expertise and interest is identified by relevant trusts to offer consultation and advice and oversee the training needs of colleagues (ibid.).

Reder *et al.* suggest that CAMHS and AMHS services have much to learn from one another. CAMHS services, in their view, have many years of experience grappling with multi-professional team work and a considerable history of being truly community-based. On the other hand, CAMHS are historically much younger than AMHS and continue to borrow from AMHS in such areas as treatment approaches, diagnostic precision, emergency service provision and academic establishment.

### **b) Consolidation of specialised services**

One of the difficulties in interface work is determining who should be responsible for providing which service. Is perinatal mental health care for mothers with mental health problems, or the provision of parenting skills work, the responsibility of AMHS or children's services? What of parental mental health problems identified as a result of family work by CAMHS workers, or child health or welfare concerns identified as a result of family work by AMHS workers? The danger, according to Reder *et al.*, of polarised views of responsibility for service provision is that neither service provides care. They suggest the solution would be a specialised, dedicated and suitably skill-mixed team, but there is a further danger that this might be divisive and, in absolving other services of their responsibility, might jeopardise skill development and collaborative working.

The classic dilemma of this kind is the dispute over age-range, whereby CAMHS have traditionally catered for younger people up to either 16 or 18 or the end of full-time education. There is not always necessarily a smooth transition from CAMHS to adult services. This has led to the development of the ABC Project piloting in Solihull & Coventry, to bridge the gap between services, while other trusts (e.g. North Birmingham, Wolverhampton and Worcester) have established Early Intervention teams covering young people with emerging psychosis between the ages of 14 and 35. The government predicts

– indeed *pledges* - that, by 2004, 7,500 people each year will benefit from 50 early intervention teams which, across the nation, will provide treatment and support to young people with psychosis and their families (Department of Health, 2001).

The NHS Plan pledges 50 Early Intervention teams, 1000 new graduate mental health staff working in primary care, 335 crisis resolution teams, 220 assertive outreach teams and an extra 500 community mental health team (CMHT) workers to bolster the existing CMHT's (ibid). If this all comes to fruition, liaison across the adult services alone could be complex enough, let alone liaison between these multifarious adult services and the range of children's services. In the light of this expansion and diffusion of AMHSs Reder *et al.*'s suggestion (above) of identified liaison staff within specific teams would seem all the more necessary.

### **c) Research**

Areas for further research suggested by Reder *et al.* include, among others, the cost-effectiveness of liaison projects and the efficacy of conjoint family work. They suggest organisations should recognise the clinical importance of such projects by prioritising research about the child/adult interfaces in their research and development strategies (ibid.). The obvious advantage of research in any area of interface is that it will impact on more than one clinical area and with more than one client group. The best outcome of research in this area may be that both CAMHSs and AMHSs are enabled to strike a balance between defending the rights of people with mental health problems to be parents whilst safeguarding the health and welfare of children who have a right to 'good-enough' parenting.

### **d) Training initiatives**

Reder *et al.* (2000) make a number of recommendations for training but their perspective is somewhat biased towards the medical profession. They recommend that training initiatives need to address both undergraduate and postgraduate programmes and suggest that both should contain modules about the child/adult interfaces. They suggest training posts be created for liaison family therapists (for example) that refine these skills and provide opportunities for research. (This present project could be seen as a modest example of this). In short, they propose that those intending to work in CAMHS or AMHS should have a *family* mental health training. (ibid.). Reder *et al.* are right to point out that this cultural shift away from an individualistic model to a family approach needs to begin with undergraduate training of all disciplines. Another aspect of training the value of which is emphasised by Reder *et al.* is the inter-service academic conference.

Falkov echoes much of Reder *et al.*'s recommendations (Falkov, 1998: 115). He suggests seven key principles for the development of inter-agency and inter-professional training which include addressing service structures and procedures, inter- and intra-agency communication, long-term support strategies and a variety of different services. Falkov also recommends the availability of a flexible and accessible range of community resources, supporting the family as a whole and developing inter-agency training.

### **Conclusions**

The scope for truly preventive work has, arguably, diminished for AMHSs since the imperative to focus on severe and enduring mental illness. Early intervention in psychosis



may be an exception to this, but it could be said that absolute primary prevention in mental health begins in childhood. Children of parents with mental health problems are a legitimate priority for AMHS workers and CAMHS workers alike, because of the “growing body of research that gives evidence to the heightened vulnerability of this population to increased rates of psychopathology, impaired cognitive processes, disturbances in interpersonal relationships and reduced overall adaptive functioning” (Garley et al., 1997: 97).

For the future positive mental health of our society, mental health workers of all disciplines and backgrounds must attend to the need to have a family focus, in which the needs of all (be they adults, children, parents or siblings) are addressed in a balanced way. In the complex and changing world of mental health care, a logical starting point is to build on the interface between CAMHSs and AMHSs, particularly using a family approach as a way of crossing bridges between the services.

## Chapter 3

# Survey of Adult Mental Health Workers

# Survey of current practice among AMHS workers within the West Midlands

In November 2002, a questionnaire was sent to all BFT trainers in all trusts in the West Midlands region (see Questionnaire 1 in appendix). The aims were to assess AMHS workers' awareness of the parental role of service users with whom they were working. It sought to gather information on the attitude of this staff group towards working with the children of parents with whom they had contact. It also sought information on links between AMHS and CAMHS workers. It was assumed that the typical respondent would be a clinician working with adults with mental health problems.

100 questionnaires were sent out with a covering letter explaining the project. The questionnaire contained 15 questions with instructions to circle appropriate responses or write in the space provided, where appropriate. It was explained that, where used in the questionnaire, the term 'Service Users' denoted "persons currently receiving a service and experiencing serious mental health problems" while the term 'Dependent children' denoted "children from 0-17 years".

## Response

By January 2003, 28 completed questionnaires had been returned. There were also four others returned but not completed. Three of these were because the respondents were not involved in clinical work currently. Another questionnaire was incomplete. The number of valid questionnaires is therefore taken to be 28.

## Results

### 1. Prevalence of service users who are also parents

#### Question 1:

In relation to service-users on your caseload/with whom you have contact, do you know whether any have dependent children?"

All 28 respondents answered 'yes'.

#### Question 2:

"Looking more closely at your caseload or current involvement with service-users, can you identify whether any of them are parents of dependent children?"

Again, a majority of 25 respondents answered 'yes'. Two respondents answered 'no' and one failed to circle either response.

#### Question 3:

Expanding on the previous question, asked: "**Roughly** what percentage of your service-users are parents?" and provided a Likert scale for the response.

It might have been expected that those who answered 'no' to question 2 would have had difficulty giving even a rough percentage. However, 15 respondents answered '0-24%' (one of these being a respondent who had previously indicated they could not identify

whether any of their service-users were parents). Eight respondents answered '25-49 %'. Three respondents answered '50-74%', while only one respondent answered '75-100%'. The latter was a community mental health nurse working in primary care. Two respondents failed to indicate a percentage, one leaving the question blank, one answering "Don't know".

#### Question 4:

"Does your organisation have a formal mechanism for recording the above information?" It asked for further details if the answer was positive.

A majority of 21 respondents answered 'no' to this. One of these suggested that it "may (sometimes) be mentioned in CPA but not always", while another added "? Via care coordination documentation". Four respondents answered 'Don't know'. Of the three who answered 'yes', all explained that this information was recorded on the care coordination documentation. It would seem from this that the only formal mechanism for recording information about the parenthood of service users was afforded through care coordination or the care programme approach (CPA). Assertive outreach teams seemed more likely to be aware of this mechanism than others.

#### Question 5:

Expanding on the previous question, asked: "Do you think this information would be useful/relevant to collect?"

Although only 3 respondents were definitely aware of a formal mechanism for recording information about the parenthood of service users, a majority of 26 felt it would be useful/relevant to collect this information. One of these qualified their answer by adding: "Possibly, but would depend on what was used for"; while another added a "very" to the initial 'yes'. One respondent added "Don't know" as the response, while only one respondent definitely answered 'no' to this question.

## **2. Prevalence and nature of practitioners' interaction with the children of service users in their care**

#### Question 6

"Do you have interaction with these children?"

A majority of 19 respondents answered 'yes'. Those answering positively were directed to Question 6a to indicate how they would characterise their usual interaction with these children, choosing from four types: "Peripheral, in-passing acknowledgement, e.g. saying hello"; "Opportunistic therapeutic intervention, e.g. if they are in the room"; "Planned, purposeful involvement with therapeutic intervention" or "Other, please specify".

The most common interaction with the children of service users was "opportunistic therapeutic intervention" (12 respondents). One person on an assertive outreach team noted that they had more contact with babies and toddlers than with older children. A team manager who described their usual interaction as opportunistic nevertheless described how, with one child, they have ongoing involvement, collecting the child from school "and talking about Mum's problems". This sounded rather more than opportunistic.

Nine respondents specified they had "peripheral, in-passing acknowledgement". Only 3 respondents engaged in "planned, purposeful involvement with therapeutic intervention",

although one respondent, not choosing to indicate this option on the questionnaire nevertheless commented that she did “nothing other than BFT” which surely requires the “planned, purposeful involvement” of children in a therapeutic intervention.

Only one respondent chose “other” and specified this as “practical support, arranging play-schemes etc as child and family (team) seem reluctant to do much”. Three respondents commented that their interaction with the children would vary depending on a range of factors: need/situation, accessibility, circumstances/ages, how well the parents are.

A minority of 9 respondents answered ‘no’ to the question: “Do you have interaction with these children?” Those who answered negatively were directed to question 6b to indicate what they considered to be the main reason for not being able to have contact with these children, choosing from four possibilities: that it is “not seen as appropriate by clinician”; or “not seen as appropriate by service-user/permission not given”; or “visits occur when children are not at home (e.g. at school)”; or “other, please specify”.

There were a wide variety of reasons given for not being able to have contact with the children, but no consensus. One respondent (a team leader) answered that it is “not seen as appropriate by clinician”. A second (a deputy manager) answered that it is “not seen as appropriate by service-user/permission not given”. A third (an occupational therapist) felt it was because “visits occur when children are not at home (e.g. at school)”. The others gave ‘other’ reasons: one psychologist explained she worked mainly in out-patient settings and rarely saw people in their homes; a nurse working in primary care felt it was “not appropriate in primary care setting unless specific concerns are raised”. (This, incidentally, was the respondent who gave the highest percentage of service users whom they believed to be parents).

Other reasons given for a lack of contact with children included one clinician who felt “currently service demands are too great to allow other than a sticking-plaster service”; while an occupational therapist argued “the majority of children are in care and seen by appointment only” and a ward manager suggested “often clients do not live with children”. One respondent stated ambiguously “not yet ready for family work” without making it clear whether this referred to a lack of readiness on the children’s part or the part of the practitioner.

### **3. Level and nature of practitioner concern about service users’ children**

#### Question 7:

“What kind of concerns have you / might you have about a service-user’s child(ren)?” It then invited the respondent to list 3 if possible.

There were a wide variety of suggestions for actual or potential concerns and considerable consensus about many of these. Responses are grouped here under four broad headings. They included:

#### a) General stress and anxiety

- Stress levels.
- Children’s lack of understanding about their parent’s mental illness and the difficulties at home.
- Specifically, the lack of understanding about parent’s symptoms.

- Their increased feelings of anxiety and need for support.
- Specifically children being concerned that it might be *their* fault.
- The need for children to be given information in order to prevent “damaging fantasies”.
- The relationship between service-user and child.
- Disruption in their lives when parent is in hospital.
- Childcare/coping in the event of parent’s relapse (e.g. single parent requiring hospital admission).
- The impact on child from mental illness, both on coping with it, psychologically/emotionally and practically; children having to act as informal carers and not being able to live a normal life, young carers; inappropriate burden of caring.

b) Concerns about the quality of parenting

- Children being at risk, possibility in some cases of neglect (of physical/emotional needs)/Actual risk due to lack of supervision/Emotional abuse – occasionally physical abuse/Lack of control.
- Concerns about the lack of skilful, appropriate or consistent parenting.
- Parent’s inability to recognise child’s needs.
- Parent’s inability to express feelings, demonstrate affection/Lack of nurturing and lack of emotional development.

c) Concerns about children’s own mental health

- Concerns about becoming ill themselves/Fears and concerns about their own mental health.
- Bullying by peers for not having ‘normal’ parents.
- Lack of an opportunity to express how difficulties impact upon them.
- Social issues (if parent socially avoidant)/Access to interaction with other children (parent/toddler groups etc.)/Developmental and socials needs of the child/Effects of parent’s problems on child’s developmental/Emotional well-being.
- Hearing things that may frighten them (e.g. suicidal)/Witnessing unusual behaviour/thoughts leading to fear.
- Future problems for children because of parent’s illness.
- Development of actual mental health or behavioural problems in the child.
- Lack of contact with parent.
- Need for information re: parent’s condition, implications for children etc.

d) Dilemmas for the therapist

Only one respondent expressed a concern from the therapist’s perspective rather than the child’s or the parent’s:

- Therapist’s difficulty in finding an appropriate level of involvement.

(One respondent also mentioned that, in the case of parents with mental illness also involved with forensic services, a concern identified was the children’s ability to understand what is happening to their parent in relation to the criminal justice system).

#### **4. Addressing practitioner concerns about service users’ children**

Question 8:

“How have you / might you address these concerns?” It then invited the respondent to list 3 ways if possible.

Again, there was a wide variety of suggestions for actual or potential actions the therapist could take. Responses are grouped here under four broad headings. They included:

#### Child-centred interventions

- Speak to child/Discuss with child/(One respondent wrote “opportunity for them to discuss any concerns with me”).
- See children when we can, (“but,” wrote one respondent, “this is infrequent”).
- Increase contact with children.
- Monitor health/development.
- Assessments to identify safety issues.
- Finding out their understanding and experience of the illness.
- Education about the illness/Provision of information/Give information to read.
- Carry out ‘formal’ work.
- Referral to young carer group.
- Supporting visiting to hospital.

#### Parent-centred interventions

- Speak to carers/Discussion with parents/Seek permission to speak to children.
- Work with the parent to address specific issues.
- Talk to user about information they could give to child.
- Home treatment.
- Support parent to access groups.
- Superficial work with mum, modelling.

#### Family-centred interventions

- Observe family unit.
- Attempt family meeting.
- Involving extended family (5 respondents mentioned this).
- Working with the whole family.
- Asking them to join in the intervention.
- BFT (10 respondents specifically named BFT, involving children if appropriate; “I have engaged using BFT with a family with young boys who were grateful for the opportunity to find out about the illness and share their concerns” and “Unless doing BFT, probably don’t address this.”).
- Open and honest relationship.

#### Community-centred interventions

- Greater support networks.
- (Parents groups and young carers groups, already mentioned, might equally fit into this category).

#### Liaison with other agencies

- Contacting/Involving/Informing/Information-sharing with other statutory and non-statutory childcare agencies.
- Social services (8 respondents named social services or child and family services, one implying that there was a lack of response: “trying to interest child and family”).
- Health visitor.
- Education/school nurse.

- Ask for young carer's assessment.

#### Therapist-centred interventions

- BFT supervision.
- *Crossing Bridges* training.

#### Question 9:

"With regard to the concerns you have just listed, which professionals or agencies would you be most likely to liaise with?" It then invited respondents to list three if possible, suggesting they might want to consult a list provided which included 'Clinical supervision', 'BFT supervisor', 'Parent's adult key worker', 'Mental Health Social Worker', 'Child & Family Social Worker', 'Family Doctor (GP)', 'Child Protection Team (ACPC)', 'Early Intervention Service', 'Child & Adolescent Mental Health Service', 'Youth worker', 'Child's School Teacher', 'Service-user's partner/spouse' and 'Parent's Psychiatrist'.

The most common response selected was 'Child & Family Social Worker' (17) followed by 'Service-user's partner/spouse' (11), 'Child & Adolescent Mental Health Service' (9) and 'Clinical supervision' (7). Respondents were just as likely to consult with their BFT supervisor (6) as with a Mental Health Social Worker (6). They were also as likely to liaise with the child's school teacher (6) as with the parent's adult key worker (5). Three respondents selected the Child Protection Team, and three the GP while an equal number mentioned the Health Visitor (which was not one of the suggested options). Only 2 respondents said they would liaise with the parent's psychiatrist and only 1 with a youth worker. None of the respondents selected the Early Intervention Team, which would suggest practitioners were not considering early onset of psychosis as a problem in the children of service users. It may also be because early intervention teams were not yet established in their areas. Apart from health visitors, there were a number of creative suggestions for other professionals or agencies. These included:

- School nurse.
- Voluntary sector.
- Formal/Informal carers.
- Tenancy Support.
- Local agencies.
- Own clinical team.
- Young Carers Project.
- Sure Start.

#### Question 10

"How confident do you feel about working with these children?" A Likert scale was provided for the response.

Only one, a Community Mental Health Nurse, felt totally confident about working with the children of her clients. A majority of 17 respondents felt "very confident". Eight respondents felt "not very" confident, while 2 respondents felt "not at all" confident. Although the majority felt totally or very confident (18), it is significant that 10 respondents felt "not very" or "not at all" confident in this important area. One of the "not at all" confident respondents added "I am not trained", implying that a lack of specialist training in working with affected children greatly determines level of confidence. Significantly, the other "not at



all confident” respondent was of the same profession and same trust as the only “totally confident” respondent.

All this would suggest that it would be wrong to simply assume that confidence in working with affected children is determined by professional discipline or employer. (For example, one psychiatrist felt “Quite confident” while a fellow psychiatrist colleague answered “not at all confident”). Clinical psychologists who responded felt “quite confident”, though indicated that the situation rarely arises in clinical practice, as did occupational therapists (OTs). Five out of nine CPNs (or CMHNs) felt “not very” or “not at all confident” while four out of twelve respondents in managerial roles also felt “not very confident”. This may suggest that nurses (who make up the largest part of the mental health workforce) tend to lack confidence in this area whereas managers (who, in this study, appeared to be predominantly more senior nurses) become more confident in this area as they become more senior. However, it does highlight the fact that mental health nurses tend to lack confidence in working with children whereas psychologists and OTs tend not to. This is likely to reflect differences in professional training that need to be addressed.

#### Question 11:

“What concerns do you have with working with these children?” It then invited the respondent to list 3 if possible.

Three respondents stated that they had “None”. The remaining 25 respondents identified a wide range of concerns about working with the children of service users. Responses are grouped here under four broad headings. They included:

- a) Lack of general knowledge or experience of working with children
  - Little knowledge or experience of working with children in general
- b) Lack of specific knowledge, training or qualification for working with children
  - Little or no specific training/Have no training in working with children with mental health/behavioural problems/Lack of knowledge of child psychiatry.
  - Not qualified to work with children under age of 16.
  - No expertise in working with children/unsure of my ability to assess potential child issues/Concerned that I will not properly recognise symptoms of stress or distress in the child.
  - Lack of awareness of legislation/local policy issues.
- c) Systems issues
  - “Adult mental health services (in which I am employed), can only offer services to people over age of 16”.
  - Conflicts of interest/confidentiality issues.
  - “Could be too many workers already involved,” with the risk of “confusing the child”.
  - Being able to liaise effectively with other agencies/Liaising avenues not made available.
  - Time pressures.
- d) Dilemmas for the therapist
  - How much information to give to children/what level of information/inability to grasp concept of mental ill health due to age/overloading children with too much information/fear of making situation worse.
  - Cannot provide the appropriate support/Having correct approach.

- Children feeling responsible for helping with parental care or perceiving self as stressor.
- Issues of risk and safety/Safety – child and client, physical and emotional.
- Parents may be unwilling to acknowledge the need for intervention.
- Not being able to contact children, as parents won't allow.
- Knowing how to deal with difficult situations.
- Children being disruptive.
- Parents' anxieties may be raised.
- Child becoming very close to CPN.
- Promoting child/parent role.
- Being left with the responsibility.

One concern expressed was that "BFT was not appropriate". Referring to one particular case:

*"BFT not appropriate (Mum persistently psychotic, unable to care for children (supported by 83 year old elderly relative). Husband works full time, drinker, gambler, domestic violence, at risk register several times. No suggestion of mental health problems in children. Currently arranging professional review in hope of engaging child and family team)."*

#### Question 12:

"Does your organisation recognise the need for training in this area?"

A majority of 22 respondents replied "No" to this question. One qualified this by adding, "our organisation has own child and family team therefore primary adult services are not trained in child issues". Another added "I'm unsure how much emphasis there is on attending ACPC (Area Child Protection Committee) Training events". One responded "BFT Update!" Another respondent who answered positively commented "Recognise the need but no money to provide it".

### **5. Links across the adult/child interface**

#### Question 13:

"Is there a professional group specialising in working with children with whom you have good links and with whom you can share support and advice across the adult/child interface?" It then asked respondents to identify them, while Question 14 asked "Is it possible for me" (the author) "to contact this person to get a CAMHS perspective of interface practice?"

A majority of 15 respondents indicated they had no such links. Of the 13 who did have links, 10 mentioned links with CAMHS, one mentioned the Children's Team; one mentioned Health Visitors while some had links with the Early Intervention service. A manager mentioned a Family Centre and a deputy ward manager had links with a BFT trainer who is working as a CAMHS Psychologist. A CMHN from had links with a consultant nurse in CAMHS, while a psychiatrist commented "we are just starting a CAMHS/AMHS working party to examine the interface issues".

Question 14 asked whether it might be possible for the researcher to contact any of the professional groups suggested by Question 13. The purpose of this question was to broaden the base of contacts in children's services that might be able to contribute to the next stage of the research (i.e. the survey of children's and young people's workers).

### Question 15:

Gave space for respondents to mention any other relevant points.

Additional comments volunteered in response to this final question included the following:

*“Child and family team in our area are very reluctant to be proactive and do community social work. Tend to see people “at risk” only. This can be very frustrating and keyworkers feel swamped with the responsibility and wanting to avoid crises”* (a CPN from an urban Trust).

*“Most of my caseload people are older and children have grown up and left home”* (an OT from an urban Trust).

*“As part of my core training I spent quite a lot of time in child services so am fairly confident in talking with children. I am less familiar with the legislation relevant to the field. In practice I very rarely have contact with children”* (Clinician from a rural Trust).

*“I work in a forensic unit which brings about a whole new set of problems for working with families. Often social relationships are severely damaged by the extent of a service user’s illness/involvement with the criminal justice system”* (a clinician in a forensic service).

*“Any contacts/support very erratic/individualised and dependant on family needs. No real structure evident in Trust”* (A clinician on an assertive outreach team).

## **6. Conclusion**

The results from this small-scale survey provide a useful complement to the literature review. Those surveyed - who are predominantly AMHS workers - estimated that, on average, 25-49% of their clients were parents of dependent children. At the same time, the majority of respondents worked in services where there was no formal mechanism for recording this information. Care coordination and CPA were the only mechanisms available to help in the collection of this information which most respondents agreed would be useful and relevant to collect.

The majority of respondents had contact with the children of their service users but this contact was typically characterised as “opportunistic therapeutic intervention”. The AMHS workers surveyed had a wide range of actual or potential concerns about service-users children. These concerns included:

- General stress and anxiety.
- Concerns about the quality of parenting.
- Concerns about children’s own mental health.
- Dilemmas for the therapist.

There was a wide-range of creative solutions to how these concerns might be addressed. These included:

- Child-centred interventions.
- Parent-centred interventions.
- Family-centred interventions.
- Community-centred interventions.
- Liaison with other agencies.
- Therapist-centred interventions.

As for professionals or agencies with which AMHS workers would liaise with regard to their concerns, respondents listed the following in order of priority:

1. Child & Family Social Worker.
2. Service-user's partner/spouse.
3. Child & Adolescent Mental Health Service.
4. Clinical supervision.
5. BFT supervisor/Mental Health Social Worker/Child's school teacher.
6. Parent's adult key worker.
7. Child Protection Team/GP/Health Visitor.
8. Parent's psychiatrist.
9. Youth worker.
10. Others.

As regards AMHS workers' confidence in working with the children of service users, the majority felt very confident but a significant minority felt "not very" or "not at all confident". The majority of respondents listed a range of concerns about working with these children, which included:

- Lack of general knowledge or experience of working with children.
- Lack of specific knowledge, training or qualification for working with children.
- Systems issues.
- Dilemmas for the therapist.

Foremost amongst these concerns was a perceived lack of general or specific knowledge or experience in working with children. This was less of a problem for OTs and psychologists and more of a problem for nurses. However, even those professionals with relevant experience felt insufficiently familiar with current legal and policy frameworks. There would appear to be a need, therefore, for relevant training for all AMHS professionals and especially for mental health nurses who make up the largest proportion of the workforce. Sadly, a majority felt that their organisations did not recognise the need for such training. It is worth noting that supervision and, specifically, BFT supervision are highly rated as sources of support, advice and information but that supervisors (being AMHS workers themselves) may also lack confidence in this area.

Across the CAMHS/AMHS interface, the majority of respondents lacked any good links with professional groups specialising in working with children. The minority who did have a link named their local CAMHS team, although fewer named particular individuals suggesting that these links may not, in all cases, have been tested out.

Overall, the results concur with the literature review and with, for example, Falkov's observation that:

Studies undertaken in AMH services suggest that a substantial proportion (at least 20%, probably one-third and in some cases up to 50%) of adults known to mental health services have children but that much less is known about the extent and nature of children's needs, including their needs for safety and protection.  
(Falkov, 1998: 11).

Many of the responses given show extreme anxiety on the part of practitioners to become involved with the children of service users. Some of this reluctance may be due to clear boundaries e.g. the surprisingly rigid-sounding comment from one BFT trainer that adult mental health services only offer services to over-16s. Other AMHS workers express legitimate concerns about competence as well as confidence and, responsibly, recognise their lack of professional training or expertise. All the literature would suggest that it is better that adult workers offer some support rather than none, however ill equipped AMHS workers may feel about taking on this role. Clearly, it is better that they have the training, support and supervision they need to provide this competently and confidently than that they avoid assuming the role for fear, as one respondent put it, of making the situation worse.

The survey highlights the need for cross-boundary work, involving CAMHS and AMHS services as well as the broader range of helping agencies that includes health visitors, school nurses and teachers. It highlights the need to develop trusting, reliable partnerships with social services and the ACPC. It also suggests that, given the further complications brought by those service users involved with the criminal justice system, it makes sense for us to work proactively in collaboration with, for example, Youth Offending Teams.

One respondent has suggested that *Crossing Bridges*, the Department of Health's training resource, could help address therapists' concerns about working with the children of service users. Another has identified that in her Trust there is a lack of a structured approach to parental mental health. This would appear to be the case in the majority of adult mental health trusts in the region. The government is committed to making CPA work nationally (Department of Health, 2001) and this may help increase awareness of "patients as parents" as well as of their "invisible" children. Nationally, consideration should also be given to ensuring that all mental health professionals (and particularly nurses) gain experience in working with children. What is needed at the level of each trust is a comprehensive training initiative to ensure that AMHS workers recognise the parenting role of their service users and develop the confidence, through good local inter-agency liaison, through family interventions training and practice, ongoing supervision and additional targeted *Crossing Bridges* training, to be able to meet the needs of families i.e. parents and their children.

## Chapter 4

# Survey of Children and Young People Workers

# Survey of current practice among those working with children and young people within the West Midlands

A questionnaire was sent, in April 2003, to 50 workers from services for children and young people, who had expressed an interest in the Interfaces Project. This group consisted, not only of CAMHS workers but, for example, YOTs and young carers project workers. Some of these contacts were targeted because they had been identified in the AMHS survey as being useful links between AMHS and children's and young people's services. The aim of the survey was to gather information about links between CAMHS and adult services. It sought information on the awareness and attitudes of this staff group regarding the mental health of the parents of clients with whom they were working. It also addressed the issue of transitions between children's and adult services since this had already been identified as a concern of many CAMHS workers. As with the previous survey of AMHS workers, the questionnaire contained 15 questions with instructions to circle appropriate responses or write in the space provided, where appropriate (see Questionnaire 2 in Appendix).

## Response

Twenty-seven completed questionnaires had been returned by June 2003. This is a higher percentage response rate than for the AMHS questionnaire, since the cohort was smaller (only 50 as compared with 100 in the AMHS survey).

## Results

### 1. Prevalence of parental mental health problems

#### Question 1:

"In relation to children/young people on your caseload/with whom you have contact, do you know whether any have a parent with any kind of mental health problem?"

All 27 respondents answered 'yes'. One added the comment "frequently, but not in all cases", a comment supported by another respondent who commented that awareness of this was sometimes dependant on disclosure. One clinician added that *all* their referrals are for parental mental health problems; hence they left questions 1-4 blank.

#### Question 2:

"Looking more closely at your caseload or current involvement with children/young people, can you identify whether any have a parent with severe and enduring mental illness (see definition above)?"

Again, a majority of 24 respondents answered 'yes'. One respondent answered 'no', one failed to circle either response and one answered 'don't know'.

#### Question 3:

Expanding on the previous question, asked: "**Roughly** what percentage of these children/young people have a parent with any kind of mental health problem?" and provided a Likert scale for the response.

10 respondents answered '0-24%'. Eleven respondents answered '25-49 %'. 3 respondents answered '50-74%', while only one respondent answered '75-100%'. Two respondents failed to indicate a percentage.

#### Question 4:

"Of these, **roughly** what percentage of these children/young people have a parent with severe and enduring mental illness (see definition above)?" and provided a Likert scale for the response.

A majority of 24 respondents answered '0-24%' to this. One clinician qualified this by adding that recurrent or inadequately treated depression "if it counted" would increase this figure significantly. One respondent added a footnote in the response to this and the previous question making the interesting point that "these numbers increase significantly if they include birth parents – many of the children with whom I work are adopted or looked after on a long-term basis...." Two respondents failed to indicate a percentage. One respondent indicated a higher percentage (25-49%).

#### Question 5:

"Does your organisation have a formal mechanism for recording the above information?" It asked for further details if the answer was positive.

A majority of 20 respondents answered 'no' to this. One of these suggested, however, that the annual DOH 'Children in Need' census records some of this information. One respondent answered 'Don't know', adding "don't think so". Of the six who answered 'yes' all explained that this information was recorded on the child's file and, with permission, could be passed on to other relevant agencies.

## **2. Prevalence and nature of practitioners' interaction with parents with mental health problems**

#### Question 6:

"Do you have interaction with these parents?"

All 27 respondents answered 'yes'. Those answering positively were directed to Question 6a to indicate how they would characterise their usual interaction with these children, choosing from four types: "Peripheral, in-passing acknowledgement, e.g. saying hello"; "Opportunistic therapeutic intervention, e.g. if they are in the room"; "Planned, purposeful involvement with therapeutic intervention" or "Other, please specify".

The most common interaction with the parents was "Planned, purposeful involvement with therapeutic intervention" (21 respondents). One worker noted that they usually discussed forms of help appropriate to address the parent's mental health issues and provided support in accessing these. Similarly, another worker provided some facilitation in accessing services for the parent. One respondent noted that, as a family therapist, they were mindful of the impact of mental health problems on the family system. A child and adolescent worker noted that, although they might provide "Planned, purposeful involvement with therapeutic intervention" for the parent, the focus remained on the outcome for the child under the team's care. Another respondent explained that they operated a system whereby a colleague would be the parent's worker for a child in therapy, or they would do parent work if the child was in therapy with a colleague.



Two respondents specified they had only “Opportunistic therapeutic intervention, e.g. if they are in the room”. However, 4 respondents who had selected “Planned, purposeful involvement with therapeutic intervention” also selected “Opportunistic therapeutic intervention”, adding “depending on the nature of the problem and/or specific requests for individual or family work and/or what other interventions they are receiving”. One child worker commented: “If you don’t help the parents’ mental health you get nowhere with the child”.

No respondents selected “peripheral, in-passing acknowledgement” as characterising their work with parents. Three respondents did not indicate any particular choice of intervention, one of these commenting, “All CAMHS work would involve not only the child but family members”. Only one respondent selected ‘Other’, explaining that “Parents could be on a Parenting Order, voluntary or statutory; could be taking part in family mediation ... unless on Parenting Order focus is on young person.”

None of the respondents answered ‘no’ to the question: “Do you have interaction with these parents?” Despite this, 8 respondents completed question 6b (which was for those who had answered negatively to Question 6 to indicate what they considered to be the main reason for not being able to have contact with these parents, choosing from four possibilities: that it is “not seen as appropriate by worker”; or “not seen as appropriate by child/young person/permission not given”; or “contacts occur when parents are not available (e.g. at work, in hospital”); or “other).

There were a variety of reasons given for not being able to have contact with the parents. These included difficulty involving the parents because the child is in care, adult mental health workers are more appropriately involved with the parent, the parent is ‘poorly compliant’, and that some family focused interventions address this but 1:1 with parents is unusual in child work. An unusual, but legitimate reason given by one worker was that “the young person wants to ‘own’ the worker for their own needs and work in confidence”.

### **3. Addressing practitioner concerns about parents with mental health problems**

#### Question 7:

“If you had any concerns about a parent with a mental health problem, which professionals or agencies would you be most likely to liaise with?”

It then invited respondents to list three if possible, suggesting they might want to consult a list provided (see appendix 3).

The most common response selected was ‘Family Doctor (GP)’ (17) followed by ‘Adult mental health service’ (16) and ‘Child & Family Social Worker’ (12). Respondents were just as likely to consult with their ‘local CMHT’ (10) as with the ‘Parent’s adult key worker (10). Then followed the ‘Parent’s Psychiatrist’ (9), ‘Child Protection Team (ACPC)’ (7) and the ‘Parent’s Community Psychiatric Nurse’ (6). Five respondents selected the ‘Mental Health Social Worker’, and only three the ‘Parent’s partner/spouse’. Only 2 respondents said they would liaise with their ‘Clinical supervisor’ if they had a concern about a parent with a mental health problem. Other suggestions included a parent & baby service, the patient himself and a department of psychological therapies/AMHS clinical psychology service.

#### Question 8:

“How confident do you feel about working with parents with mental health problems?” and provided a Likert scale for the response.

Five respondents felt totally confident about working with parents with mental health problems. Four of these were known to have an adult mental health nursing backgrounds. A majority of 18 respondents felt “quite confident”. Four respondents felt “not very” confident. No respondents indicated that they were “not at all” confident.

When compared with the equivalent question in the AMHS survey (about confidence levels of AMHS workers working with service users’ children) the children and young people’s workers tended to be more confident in working with parents than the AMHS workers were in working with children. This may reflect the fact that many of the young people’s workers had a professional background in working in adult mental health, whereas AMHS workers tend to have less clinical experience of working with children.

#### Question 9:

“What concerns do you have with working with these parents?” It then invited the respondent to list 3 if possible. Four respondents stated that they had “None”. The remaining 23 respondents identified a wide range of concerns about working with parents with mental health problems. Responses are grouped here under four broad headings. They included:

- a) Lack of general knowledge or experience of working with parents with mental health problems
  - “Lack of sensitivity to identify when parent is overwhelmed”.
  - Lack of training.
- b) Lack of specific knowledge, training or qualification for working with parents with mental health problems
  - “Lack of clinical knowledge of the illness”/“condition/prognosis for improvement”.
- c) Systems issues
  - “Poor service delivery and organisation”.
  - “Difficulty getting cooperation/joint working arrangements due to pressures on CAMHS and AMHS/lack of communication (different beliefs, values etc).
  - “Case conferences often ineffective”.
  - “Resource/time limitations”.
  - Totally inadequate family support/housing/pastoral support.
  - Impact on children of attitudes/approaches of other key professionals.
  - “Impoverished understanding of social services staff leading too frequently to the involvement of child protection services”.
  - Adult mental health not within the remit of the service (e.g. YOTs).
- d) Dilemmas for the therapist
  - To consider the impact of adult mental health problems on child development.
  - Role conflict/conflicts of interest (what is in the child’s or adult’s best interest)/parameters between working with child and working with adults as parents and individuals/ensuring/facilitating parents are simultaneously supported rather than providing a direct service to them as well as their child.

- Frequent difficulty of parents to fully engage in wider aspects of childcare (“i.e. Proactive emotional/educational/recreational stuff”).
- Volatile/unpredictable behaviour – child safety.
- Parents’ difficulty fully participating in therapeutic processes for their children.
- Interfering with (or duplicating) AMHS workers’ role/responsibilities; offering conflicting advice or therapeutic model.
- ‘Poor compliance’.

One CAMHS worker summarised the situation well: *“There need to be clear boundaries around the work. I would only get involved in what impacts on the child – the parent would need their needs addressed by AMHS professionals.”* She then goes on, as if to acknowledge the complexity of this statement, by adding: *“Sometimes roles can feel conflicting, though the bottom line is that CAMHS is about meeting the child’s needs – sometimes these can only be addressed by the parent’s needs being met.”*

#### Question 10:

“Does your organisation recognise the need for training in this area?”

A majority of 13 respondents replied positively “Yes” to this question. One qualified this by adding “sporadically”. Another added “immediate colleagues” in place of the word ‘organisation’, and “encouraged by myself and other colleagues” One respondent added “have raised the concept of ‘Crossing Bridges”” 10 respondents answered “No”, while the remaining 4 respondents (for want of a “Don’t know” category) answered “unsure”, “sort of”, “only within psychology service, not within CAMHS as a whole” and “is an increasing recognition for, in particular having (training in this area) for adult services staff ... more than for CAMHS staff”. Compared with the equivalent question in the AMHS survey it seems that there is a greater recognition of the needs of children and young people’s workers to receive training in working with parents with mental health problems than there is for AMHS workers to receive training in working with children. There was also greater ambiguity about organisational recognition in the children and young people’s cohort.

#### **4. Links across the adult/child interface**

##### Question 11:

“Do you regularly discuss interface issues with your local adult mental health service and is there a particular person with whom you liaise? It then asked respondents to identify them.

A majority of 19 respondents indicated they had some links. Of these one highlighted the work of the Transitions steering group (see ‘Overview’ section) “which takes on issues to do with children and parents who have mental health problems as per ‘Crossing Bridges”” Another respondent also stressed the importance of the Transitional CPN post in her area. A CAMHS worker replied that they had begun to liaise with the lead AMHS psychiatrist and mentioned ACPC initiatives in the area (also see ‘Overview’). Some replied positively to the question but added “no particular person”, some liaising on a case-by-case basis with key workers, as and when issues arise. One clinician named the AMHS team leader and also the SureStart Project leader as key links. One worker replied that they were developing this aspect of practice with a colleague. Another noted that there was increasing significance being placed on this area, and also mentioned the importance of the ACPC. One respondent replied that she had irregular contact with primary care workers but noted there was no joint protocol in place to facilitate this work, whereas two

respondents from another Trust explained that a subgroup had been set up within the area to address this.

One respondent felt liaison only occurred in terms of 16-18 year olds, while another felt that the confidentiality of adult services can endanger children, with AMHS psychiatrists being often unwilling to discuss cases except via the child psychiatrist. For some, then, there is work going on at a strategic level, for others it is on a case-by-case level. Liaison often seems to occur between medical colleagues in CAMHS and AMHS but this may create conflicts in multi-disciplinary teams. Three respondents left this question blank, while five answered “no”, one adding “disappointing”. Nevertheless, when compared with the AMHS survey, where the majority felt they had no such links with children’s services, the perception of the majority of the children and young people’s cohort felt they had some kinds of links with AMHS.

## **5. Transitions from children and young people’s services to AMHS**

### Question 12:

“Roughly what percentage of the children/young people with whom you work are, in your view, likely to need specialist adult mental health services as they get older?” (Likert scale).

12 respondents answered ‘0-24%’. 9 answered ‘25-49%’ (one respondent indicated both ‘0-24%’ and ‘25-49 %’). 3 answered ‘50-74%’. No respondents answered ‘75-100%’, but one failed to indicate a percentage while one respondent deconstructed the question by commenting: “depends how you define services. Some may actively not ‘need’ the kind of ‘help’ offered!”

### Question 13:

“What sorts of difficulties are these children/young people most likely to be experiencing?”

A wide range of responses, some describing behaviours, others using diagnostic labels, many overlapping, were suggested. These are listed in order of frequency, using the original terminology of the respondents themselves:

- Depression (16).
- Psychosis/early onset psychosis (13).
- Anxiety/stress (9).
- Autism/Autistic/pervasive developmental disorders/ASD (4).
- Conduct disorder/oppositional defiant disorders (4).
- Personality disorder(s) (4).
- ADHD (3).
- Eating disorders/anorexia (3).
- Issues related to/impact of childhood abuse (3).
- Loss, separation, poor early attachments/attachment disorder (3).
- Self-harm (3).
- Delayed developmental achievements/developmental disorders (2).
- Mood disorders/bi-polar mood disorder (2) (see ‘depression’ above).
- OCD (2).
- Relationship problems/difficulties (2).
- Substance misuse/drug usage (2).
- Aspergers (1) (see ‘autism...’ above).

- Behavioural difficulties (1) (see ‘conduct disorder...’ and ‘ADHD’ above).
- Bereavement (1).
- Chronic mental health problems (1).
- Family breakdown (1).
- “In the public care and impact of that” (1).
- Low self-esteem (1).
- Schizophrenia (1) (see ‘psychosis...’ above).

#### Question 14:

“How easy do you feel it will be for these children to make the transition from services for children/young people to specialist adult mental health services?” and provided a scale for the response. Question 15 gave space for respondents to mention any other relevant points and many chose to use this space to expand on their answer to the previous question.

Regarding Question 14, a majority of 15 respondents answered “somewhat difficult”. Seven answered “very difficult”. Only one respondent answered “somewhat easy” while none answered “very easy”. Two respondents failed to indicate any particular choice but made additional comments: “depends *who* they see and their attitude/knowledge/skills base. Different priorities/cut-offs CAMHS v AMHS...”; “... difficult to answer – I have made several successful referrals to AMHS when the young person has reached the age of 16. However, if the young person is discharged before 16, he/she may not wish to access AMHS so readily....”

It is striking that none of the respondents felt it was “very easy” for young people to make the transition to AMHS. Others highlighted “a real need for specialist provision for the 16-25 age group”; “inadequate services for adolescents, takes too long for them to obtain services”; “no clear planning at a service commissioning level for transitions of young people. Tends to occur on an ad hoc basis”; “age group 16-18 disadvantaged in accessing services in all areas...”; “teenagers consider (AMHS) to be an old persons’ service”.

Several respondents used Question 15 to indicate optimism, or at least to make some positive suggestions for improvements, in the area of interfaces between services. Two respondents mentioned how they are currently beginning an audit on transitions across CAMHS/AMHS. One noted that: “often people know what good practice is (in the differences in agendas and service thresholds between AMHS and CAMHS). The problem is making the time available to do it”. Another respondent pointed out that parental mental health has only been recognised as important in the past 2-3 years, and felt it was crucial that more training be provided for ‘non-psychiatric trained workers’. Another, acknowledging that 16-18 transitions was ‘problematic’, felt that ‘DBT-lite’ (a variant of Dialectical Behavioural Therapy) held promise as an intervention for this age group.

One respondent supported the need for joint training and joint working initiatives and proposed “family teams including both CAMHS and AMHS workers”; another felt that “AMHS and CAMHS are separate entities - different cultures, languages, referral criteria with no opportunities for joint training or working”. The theme of cultural separatism was expanded upon by another CAMHS worker: “AMHS remain *patient*-focused and not a *wider systemic* basis; services are not child/young people-focused to any great degree....” They also highlighted other areas of concern such as:

- Children/young people visiting parents in hospital with lack of support and inappropriate visiting rooms (see section on the Goldenhill Project).
- Lack of awareness of AMHS workers about the needs of children of parents with mental health problems.
- Need for training in children's welfare/protection (particularly for AMHS workers).

Finally, one respondent pointed out that: "there continues generally to be too little emphasis on the provision of *family* mental health services. I consider BFT to be an effective medium through which such services can be delivered". (This would seem to be borne out by the case study described elsewhere in this report).

## 6. Conclusion

Having followed on from the survey into current practice among AMHS workers within the West Midlands, it is inevitable that the results of this survey of those working with children and young people should be seen in the light of the earlier one. A noticeable difference was that, although the cohort of children/young people's workers was smaller than with the cohort in the previous survey, the percentage response rate was higher. This may reflect a greater enthusiasm to participate in the debate about CAMHS/AMHS interfaces. The other notable difference was a greater degree of ambiguity in the responses given, with more children/young people's workers choosing 'don't know' as a response to questions, or circling more than one choice in their answers. They were also more likely to add comments, some of which seemed to challenge the assumptions underlying the questions. This may indicate what several respondents referred to as cultural, linguistic and even ideological differences between CAMHS and AMHS.

100% of respondents knew, in relation to children/young people on their caseload/with whom they had contact, whether any had a parent with any kind of mental health problem. A majority of these indicated they were able to identify where these parents had a severe and enduring mental illness. Most of these estimated that '25-49 %' of children/young people with whom they had contact had a parent with some kind of mental health problem. They also estimated that '0-24%' had a parent with severe and enduring mental illness. Most respondents felt their organisation had no formal mechanism for recording the above information, although in three Trusts, staff felt there was a mechanism in place.

Regarding interaction with these parents, 100% of children/young people's workers indicated they had some interaction, the most common being characterised as "planned, purposeful involvement with therapeutic intervention". This is an interesting contrast with the AMHS cohort who, in answering an equivalent question about interaction with the children of AMHS service users, gave "opportunistic therapeutic intervention" as the most common response, with the smallest minority providing "planned, purposeful involvement with therapeutic intervention". With regard to working with parents, one respondent commented: "If you don't help the parents' mental health you get nowhere with the child".

When asked how confident they felt about working with parents with mental health problems, the majority of respondents indicated "quite confident". When compared with the equivalent question in the AMHS survey the children and young people's workers tended to be more confident in working with parents than the AMHS workers were in working with the children of their own clients. This may reflect the fact that many of the young people's workers had a professional background in working in adult mental health, whereas AMHS workers tend to have less (if any) clinical experience of working with children.

Although the level of confidence about working with these parents was high, the group identified a wide range of concerns about working with parents with mental health problems in categories which mirrored AMHS workers' concerns about working with children.

Lack of training or specialist knowledge in adult mental health was identified by several as a concern. When asked whether their organisation recognised the need for training in this area, a majority replied positively "Yes" to this question. Compared with the equivalent question in the AMHS survey it seems that there is a greater organisational recognition of the needs of children and young people's workers to receive training in working with parents with mental health problems than there is for AMHS workers to receive training in working with children.

Transitions from children and young people's services to AMHS was a particular concern of this group, the majority believing that up to 24% of their clients would be likely to need specialist adult mental health services as they got older, the main problems being depression and psychosis. Most felt that this transition would not be easy, with many calling for specialist, timely provision for the 16-25 age group.

Many areas were beginning to audit transitions. Several mentioned the need for joint training and joint working in parental mental health, possibly as a way of bridging the gap for service users and providers. Some saw AMHS and CAMHS as separate entities with different cultures, languages, and referral criteria, this theme of cultural separatism being eloquently expanded upon by one commentator who felt AMHS remained *patient*-focused rather than having a *wider systemic* basis, while services are rarely child/young people-focused. Another respondent bemoaned the general lack of emphasis on the provision of *family* mental health services and argued that BFT is an effective medium through which such services can be delivered.

## Chapter 5

# Overview of Links Between Mental Health Services for Children, Young People and Adults in the West Midlands



# **Overview of links between mental health services for children, young people and adults in the West Midlands**

## **BACKGROUND**

This overview of a variety of services and projects has inevitably been a very selective and somewhat random sample. The following examples are 'snapshots' of service provision and this must be taken into account when considering service development. Nevertheless, it serves to highlight areas of good practice around the West Midlands, and points of interest arising from these. We are aware that certain areas will have been somewhat neglected, notably Staffordshire, Herefordshire and the Black Country. This does not in any way imply that these areas lack examples of good practice and innovation, but is simply the result of lack of either time or serendipity. Similarly, this survey may be criticised for focusing overmuch on South Worcestershire). This reflects a bias in that the author was seconded from Worcestershire Mental Health NHS Partnership Trust, and for the early part of the project was attached to the Worcester CAMHS service. From the starting point of Worcester's CAMHS service, the overview then ranges across other parts of the region attempting, en route, to draw out recurring themes which had already had begun to emerge from the literature review and the two surveys of workers in the field.

## **SERVICE 1 – WORCESTERSHIRE CAMHS SERVICE**

Throughout the first six months of the Interfaces Project, the author spent time observing the Worcester CAMHS Service at work. Originally, it was envisaged that this placement would form the core of the project but, after further discussion with those overseeing the project, it was agreed that it would be useful to include some broader 'mapping' of activity in the West Midlands region generally.

The Worcester CAMHS Service is part of Worcestershire Specialist Children's Services which are managed by Wyre Forest Primary Care Trust. It is one of three CAMHS services county-wide. There are also services at The Pear Tree Centre in Redditch and at Kidderminster Hospital. The Redditch service is well developed but it is acknowledged that the Kidderminster service has, for some time, been under-staffed. It was thus felt the Worcester team were in a better position to provide an observational placement. The Worcester service is based at Newtown Hospital in Worcester and serves Worcester City, Evesham, Malvern and Droitwich. It provides a service to children aged 0-16 years. The service describes itself as an outpatient service offering advice and support for both children and their families concerning mental health issues either on a 1:1 basis or as a family. Services offered include psychiatric assessment, family therapy, psychotherapy, counselling, speech and language assessment, play therapy, psychological interventions and social work.

### **Worcester CAMHS Team**

The staff team consists of Community Psychiatric Nurses (CPNs), social workers, consultant child psychiatrists, consultant child psychologists, a psychotherapist, speech therapist and medical trainees. During my placement there have also been nursing, social work and psychotherapy trainees. The service is available to children with emotional,

behavioural or developmental disorders and referrals are accepted from GPs, social services, school psychology services and health visitors.

All four of the CPN posts in the team have a dual role as Primary Mental Health Workers (PMHWs). The role of the PMHW is to offer support, education and training in child and adolescent mental health issues, to provide services aimed at preventing the development of mental health problems in children and to form improved links between voluntary and statutory organisations (see Box 1).

## Therapies and disciplines

One of the most striking aspects of the Worcester CAMHS service is the way that differing treatment approaches are used by different disciplines within the service. By contrast with most adult mental health services, there is a great emphasis on individual psychotherapy which is organised through the psychology department. Within the department there is a child psychotherapist, a trainee psychotherapist and a nurse employed to work with the

### **Box 1 - Primary Child and Adolescent Mental Health Workers (PCAMHWs)**

The 1995 Health Advisory Service (HAS) report proposed the creation of a specific new role in Tier 2\*: the Primary Child and Adolescent Mental Health Worker (PCAMHW). The role of the PCAMHW is to

- Consolidate the skills of existing primary care workers (Tier 1)
- Help primary care workers to develop new skills and build their confidence through training and education
- Aid recognition of CAMH disorders and their referral to more specialist tiers, if appropriate
- Assess and treat some individuals with mental health problems who are considered appropriate for management in Tier 1 level services

PCAMHWs were expected to be integrated within CAMHS (Tiers 2 and 3). The role is not to be confused with that of the Primary Care Mental Health Worker (PCMHW) propose in the NHS Plan (2000)-, the latter being a group of “one thousand new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness, ...employed to help GPs manage and treat common mental health problems in all age group, including children....”

\*(for an explanation of ‘tiers’ see appendix *Pyramid of CAMHS Provision: the ‘tiers’ system explained*)

parents of children undergoing psychotherapy. The CPNs and social workers are the driving force behind the family therapy clinic, with which psychologists and medical staff currently seem to have no involvement. The author was particularly interested in observing family therapy in action since the approach differed so greatly from Behavioural Family Therapy (BFT). Alongside routine assessment and support of children and their families, which was carried out by all disciplines, a debate has been taking place about the management of urgent referrals of children who deliberately harm themselves. Both family therapy and deliberate self-harm will be considered in greater detail here.

### **Family therapy**

Family therapy is offered to a number of families in purpose-built facilities and is organised as a clinic, with families being booked in, with sessions usually spaced at three-weekly intervals. Families are seen by two co-therapists while at least two of their colleagues observe through a one-way mirror

with sound and video link. Sessions are video-taped with the families consent. The style of

therapy is described as systemic and eclectic. Some of the therapists have had systemic family therapy training to a certain level and it is usual for an untrained therapist to co-work with a trained one. Sessions are organised so that a break is taken after 30 minutes to allow for conferring between the therapists in the room and those observing. Discussion and brainstorming of potential interventions is welcomed and the author was pleased to be invited frequently to offer a 'BFT-perspective' on the family under consideration.

Adult mental health service (AMHS) workers attempting to work with families are encouraged to see families in their own homes at times convenient to the family and this can mean out-of-hours work. The assumption is that, when asking families with a severely mentally ill adult to take part in BFT, it may be necessary to offer the therapy on the family's own terms, on *their* territory, in *their* free time. Those involved in the family therapy clinic at Worcester CAMHS felt, by contrast, that if the service is set up clearly and well-run, families will respect this and make efforts to travel to the hospital and to take time out from school and work. It could be that the motivation is different: families referred to CAMHS usually involve at least one parent who is anxious to resolve their child's problems and will cooperate with professionals to achieve this; families receiving AMHS being offered BFT may involve adults who are confused, angry and ambivalent about their relationship with the family member with a mental health problem and the services involved.

After working with several families in their own homes, sometimes at evening-time, sometimes recording with a small portable cassette-recorder placed on the coffee table, the author was struck by the symbolism of clinic-based family therapy. From the family's point of view, there are two visible workers and a number of 'invisible' workers involved, all sharing their expertise to help resolve the family's difficulties. The venue is a unit with purpose-built rooms, a hidden camera, a discretely-placed microphone, and a one-way mirror. A curtain is drawn open to signal the start of the session (and allow the observers who are sat quietly in a darkened adjacent room) to see (and to film) and then drawn closed at the break. At the end of this interval the curtain is opened again. To an observer (or spectator) there are obvious echoes of the world of theatre, film-making and cinema. More than one family implied that they were flattered that so much time, trouble, expertise and manpower were going into helping them – something which may be lost in the familiar surroundings of a home-based BFT session.

As a result of growing curiosity about the differences and similarities between BFT and the family therapy practised by Worcester CAMHS, the first author offered to give a presentation. This took place on at a regular multi-disciplinary team meeting which served the dual purpose of business meeting and training event. The aim of the presentation was to introduce the team to the Meriden Programme and the concept of family interventions in psychosis. The objectives were:

- To familiarise CAMHS workers with the work of the Meriden Programme.
- To give participants a general understanding of family interventions in psychosis.
- To identify differences and similarities between CAMHS approaches to families and family work and BFT.
- To encourage CAMHS workers to consider undertaking BFT training in order to adapt it for their own work and to promote inter-agency collaboration between CAMHS, AMHS and the EI team.

The feedback was that the CAMHS team found it useful and interesting, and would have liked more time to learn more about the approach. There was some interest from the team to explore the possibility of training in the full approach.

### **Deliberate self-harm (DSH) – case description**

At the start of the placement with the Worcester CAMHS team a discussion was taking place about how best to deal with deliberate self-harm (DSH) in under-16s. Up until this time, medical staff providing cover to the children's ward had carried out assessments of all DSH cases. This cover to under-16s was now ceasing and the CAMHS team had been asked to provide this service. Initially, the nurses and some of the doctors in the CAMHS team had agreed, in principle, to take part in an on-call rota so long as they were provided with some additional training. What remained unclear was the involvement of other disciplines, and there was ongoing debate about the equity of this situation. Against this background, the author was privileged to join one member of the team in a DSH assessment.

The author was contacted by a team member following a request to assess a 15 year-old girl who had taken an overdose and was currently on the children's ward. Together we visited the ward to assess her. A major difference with the assessment of children is that liaison with the child's parent is essential. The child cannot be discharged home until the assessing professional has spoken with the parent(s).

The girl assessed appeared to be depressed following the accidental death of a male school friend. She appeared to lack emotional support at home and at school. The impression was that there was a risk of a repeated DSH and it felt it would be best to offer her a routine follow-up appointment within the CAMHS service. One of the issues of running a DSH service is that it opens another gateway into the service. By the very nature of DSH cases, the urgency of follow-up appointments tends to override the waiting list and so those members of staff taking part in the DSH rota found they were taking on routine

#### **Box 2 - The Noah's Ark Trust**

The Noah's Ark Trust (founded in 1998) is a grief support service for bereaved children and young people in Worcester. Noah's Ark is staffed by a team of appropriately qualified professional staff, assisted by volunteers who are carefully selected, trained and supervised. They provide a support programme for children, young people and their families that is comprehensive and respectful of individual needs and wishes.

[www.jks.org/nat](http://www.jks.org/nat)

referrals via the waiting list and more urgent work in parallel. This additional workload, as well as being quantitatively greater, was also qualitatively more stressful since listening to survivors of DSH (and making decisions about future risk) can be demanding work, especially if the service does not provide additional support and supervision. Attempts had been made to mitigate these stresses by arranging to work in pairs for DSH assessments. Placing two members of staff on stand-by for the DSH rota, however, also had greater implications for the time management of the team.

Given the pressure on the CAMHS team through the combination of their routine waiting list and

the intake of referrals via the DSH route, the author wondered whether the team might not refer some of the cases such as the one we had just seen back to primary care for follow-up there. Another option was to refer the patient to the Noah's Ark Trust (see Box 2) for support and help with her unresolved grief. Perceptions (from an adult mental health background) were that the girl's depression was not severe and that common mental health

problems ought to be dealt with in primary, rather than secondary, care. Furthermore, there may be advantages in not 'pathologising' or stigmatising her grief but suggesting instead help away from formal mental health services, such as a primary care or voluntary sector counsellor. The CAMHS team viewed the situation differently. First, the CAMHS workers are clear their priority is to make themselves available to children and young people with mental health problems. Second, the team was very conscious of data on suicide in young people which suggested that, while suicide was on the decrease generally, the 15-19 age group were an exception to this trend (especially females). Seen in the light of this, the 15 year old girl was a real cause for concern and it was judged unsafe not to offer her CAMHS follow-up. This example demonstrated at one level there is a need for information/training from one service area to be disseminated across other services – in order to assess levels of risk which are clearly different in adult and children's presentations.

## **SERVICE 2 – SOLIHULL CAMHS SERVICE - The status of family therapy**

The Solihull CAMHS Service provides an interesting contrast with the service in Worcester. The establishment of dedicated Family Therapist posts in the Solihull team seems to have raised the profile and esteem of family therapy within the service. Family therapy is seen as a core intervention and is highly regarded by all disciplines whether or not they actively take part. This is in contrast with the Worcester service where it seems to be regarded by some as an optional intervention only carried out by disciplines such as nurses and social workers. This is similar to the position occupied by BFT in some adult services, where it is seen as an optional extra rather than a core activity of the service.

I was interested in how the family therapists fitted into the CAMHS team. It seems they have adopted a reciprocal role whereby they share their expertise by encouraging other team members to co-work with them in family therapy while themselves sharing in the other key tasks of the team – e.g. general assessments and taking part in the DSH rotas etc. (They had also developed good links with schools, universities and the On-Track service which aims to prevent young offending). Because the family therapists (who have both received a high level of specialist training) are not used exclusively for family therapy they have avoided being seen as precious or aloof whilst, at the same time, making family therapy respectable not just as an intervention but as a discipline. Their willingness to share knowledge and skills and the transparency of their practice was demonstrated by the way they invited me, with the agreement of families, to take an active part in family sessions.

### **Multi-disciplinary leadership**

A major difference between the Solihull and Worcester CAMHS teams is that the team leader in Solihull leads a multi-disciplinary team. Worcester has a uni-disciplinary team leader who leads the nurses in the team but there is no manager at a team level below the countywide service manager. Consequently, Solihull seems to have greater parity and equality between disciplines which promotes cross-disciplinary work and prevents professions that traditionally might be perceived as more powerful (e.g. psychiatrists and psychologists) from maintaining an elite separatism. This multi-disciplinary team leadership approach has been used in some AMHS for some considerable time and lessons can be learnt from this.

### **SERVICE 3 – NUNEATON COMMUNITY MENTAL HEALTH TEAM**

A CPN Specialist Practitioner (CAMHS) with Nuneaton Community Mental Health Team in North Warwickshire has the remit to help young people who might otherwise, because of their age, have fallen between CAMHS and AMHS. The post-holder was previously a CPN in AMHS and has been trained in BFT. Because of the huge demand, she is increasingly drawn into assessing young people who have deliberately self-harmed. Although this is part of her role, she feels more of her time should be spent helping young people make the transition from CAMHS to AMHS.

The specialist practitioner has used interventions such as BFT and particularly Dialectical Behavioural Therapy (DBT) in her role and has felt the skills of both useful – DBT being particularly useful for the large number of young women seen who have personality disorders. This is a client group that CAMHS workers (in Worcester, Solihull and Nuneaton) who cause great anxieties because their problems may not simply evaporate as they become adults and so a smooth transition to adult services would be helpful in these cases. However, because of the controversial nature of this diagnosis – and the management problems that personality-disordered young people often present – AMHS are often reluctant to accept such referrals.

### **SERVICE 4 – TRANSITIONS**

As in Worcester, the Solihull CAMHS team described having had some difficulties with AMHS not accepting referrals of young people who were making the transition into the adult age group. This is a difficult and often contentious issue and is in part, looking to be explored further via the pilot project.

#### **The West Midlands Transitions Pilot**

In Autumn 2002 a proposal was accepted for two pilots in the West Midlands to “improve access to mental health services for young people by managing transitions”. It was supported and funded by the NIMHE Access, Booking and Choice Project. Both Coventry PCT and Solihull PCT were keen to appoint Transitions workers and so became the piloting trusts in the West Midlands. The author was delighted to be asked to join the working group given the project the Meriden Programme was undertaking.

The proposal was to pilot the role of transitions workers to improve the current poor access to mental health services experienced by young people in and around the 16-19 year age group. Each pilot would run for up to one year and would receive support in project management, research, evaluation and dissemination. It is hoped that the work of both Transitions pilots will be informed, to some extent, by both the Interfaces project and the experiences of other practitioners in the locality.

Both Solihull PCT and Coventry PCT appointed Transitions Workers, by April 2003. Both were finding it difficult to engage AMHS in a dialogue. A ‘Transitions Conference’ had been held in March in Birmingham which was well attended although, again, those attending were predominantly from CAMHS rather than AMHS.

The Solihull Transitions Worker felt it was important that Transitions Workers have a clinical role as this gives the post greater credibility in the eyes of hard-pressed workers from both CAMHS and AMHS. It is hard to identify problems or suggest solutions if the worker is no

longer actually seeing patients. Her first impressions were that CAMHS services were sometimes too clinic-based. Ironically, mental health nurses in CAMHS still tended to describe themselves as 'CPNs' even though they often did little community-based work. The post-holder also felt there was a gulf between the (largely systemic) family therapy done by CAMHS services as compared with AMHS services' almost total lack (with the exception of BFT) of family work. She agreed that BFT could form a bridge between the services if (a) AMHS were able to fully implement BFT and (b) CAMHS services were prepared to explore the value of family intervention other than systemic family therapy.

## **SERVICE 5 – SOUTH WORCESTERSHIRE EARLY INTERVENTION SERVICE**

The service provides individual, group and family support for people who have recently experienced psychosis. They had formed close links with Worcester's CAMHS team, and were auditing a group of young people with possible emerging psychosis with the aim of describing the group and helping staff to identify those who would benefit from early intervention.

The Early Intervention Service places great emphasis on psychosocial interventions including BFT, has a community-orientation and practices an assertive outreach model. They have strict referral criteria: the client must be aged 14-35, must live in the South Worcestershire catchment population and must have experienced a first episode of psychosis within the past year. These criteria have meant that they have not been able to accept referrals made by the local CAMHS team for young people who are 'transitional' but without psychosis. Worcestershire has no transitional workers as yet, while North Worcestershire has no Early Intervention Service.

A collaborative agreement with the CAMHS service means that 14-16 year olds will be shared between CAMHS and EI, 16 year olds upwards being 'walked through' by the EI team. The EI service is an in-hours service only. The crisis teams will provide out-of-hours cover for EI as they do for the assertive outreach service and AMHS generally. One area of need that has not yet been resolved is that of out-of-hours or crisis support for under-16s.

## **SERVICE 6 – BIRMINGHAM YOUNG PEOPLE'S HEALTH PROJECT**

### **Box 3 – The Night Shift**

*The Night Shift* used creative arts and craft workshops (with costumes, storytelling etc) with 13 young people aged 11-13 from both genders and different ethnic backgrounds. The event was very different from a traditional 'sleepover' and highlighted a number of mental health issues. The young people involved, while not admitting to 'mental health problems', were more than willing to discuss their 'problems of stress'. Mental health issues identified included:

- loss and bereavement
- dealing with stress
- confidence and self-esteem
- family issues

The project is led by two enthusiastic workers from the Youth Service and serves the localities of Hodge Hill and Yardley. The project had organised a successful activity in October 2002 called *The Night Shift* (see Box 3) which was partly funded through the youth festival and aimed to explore the issues of young people and mental health by linking the theme of dreams and nightmares with young people's hopes and fears.

The Project has links with Birmingham Young Carers (see below) and was keen to explore how it could consult with young people on mental health. It illustrates how there is energy within the youth and education services for engaging in mental health promotion activities with children and young people. It would be helpful if CAMHS, Early Intervention and Young Carers services could develop their collaboration with groups like the Young People's Health Project in order to optimise the effectiveness of initiatives like *The Night Shift*.

## SERVICE 7 – NCH: BIRMINGHAM YOUNG CARERS

### Box 4 - NCH

NCH is one of the UK's leading children's charities. Through more than 480 projects they work with over 98,000 vulnerable children, young people and their families with the aim of giving them the opportunity to reach their full potential.

[www.nch.org.uk](http://www.nch.org.uk)

Birmingham Young Carers currently offers a comprehensive support service to children and young people aged 5 to 17 who care for a parent or sibling with a mental or physical illness, disability, drug or alcohol problem (see Box 4). They operate an open referral system and currently receive between 2 and 5 new referrals every week from parents, young people themselves, Social Services, Schools, Health, Youth Services, Connexions (see Box 5), neighbours and local churches. They have a small staff team comprising a Project Manager, a Personal Advisor (seconded from Connexions), 2.5 Project Workers and some sessional staff.

At present there are over 150 children and young people

registered with the project, which is working to full capacity (and beyond). As a result, and like most service providers in the city, they now have to operate a waiting list for all new referrals. They provide one to one support for those young carers with the greatest needs, living in the most difficult and complex family circumstances. The project also provides a varied, fun and educational programme of activities and breaks throughout the year as well as group work sessions with an emphasis upon building confidence and self-esteem, communication, life and social skills. They use games and activities to encourage young carers to make sense of their lives and roles, to speak about their feelings and concerns and to enable them to grow and develop emotionally, physically and spiritually.

### Box 5 - Connexions

Connexions is a nationwide service for all young people aged 13-19 (or up to 25 if they have a learning difficulty or disability). They work with young people "to raise their hopes, have greater self-confidence and encourage them to make the most of their life". Connexions provide advice, information and support on any topic, working through schools, colleges and Connexions Centres. A Connexions worker is known as a Personal Advisor (PA).

[www.connexions.co.uk](http://www.connexions.co.uk)

Many young carers live in the poorest households, dependant upon benefits and have poor diets and health as a result. Many of them, as well as caring for parent(s) with mental illness and disorders, also suffer themselves with mental health difficulties relating to abuse, loss, isolation, insecurity and fears for the future.

Birmingham Young Carers works closely with other (statutory and voluntary) agencies in order to get the best level of support possible for young carers and their families. They provide awareness training for teachers, learning mentors, school nurses, youth workers and other professionals to increase their understanding of the impact of caring and of the



needs and vulnerabilities of these children and young people. They also work with schools, youth projects and hospitals to enable more effective identification and signposting of young people, to increase the 'visibility' of young carers.

Birmingham Young Carers is the only organisation currently providing a service for children and young people for the City of Birmingham (there is a similar project for Solihull – Crossroads). They hope to work in partnership with other agencies to enable the project to grow and develop. It is thought that there may be as many as 5,000 young carers living in Birmingham and the project's long-term vision is for a designated Young Carers' Centre for the city (working alongside locality-based provision), which would be accessible to all.

### **SERVICE 8 – BIRMINGHAM YOUTH OFFENDING SERVICE**

Throughout the course of the Interfaces Project, the Birmingham Youth Offending Service has been working with the Meriden Programme in exploring the relevance and availability of family work training for Youth Offending Teams (YOTs). It was felt that through discussions with workers from this setting and trainers in BFT that the approach would be invaluable in giving workers a structured way of working with families. It seemed the core components of communication skills and problem solving would be very relevant in families of young offenders.

Issues such as the lack of clear evidence-base for BFT within this service setting and the aspect of compulsion in terms of 'parenting orders' means that any training needs to acknowledge and address this. YOTs in Shropshire have also expressed an interest in BFT training and so the intention is to 'pilot' the adapted BFT training with the Birmingham service with the possibility that other YOT teams in the region may benefit from the training in the future.

### **SERVICE 9 – MENTAL HEALTH DAY CENTRE, LUDLOW, SHROPSHIRE**

A Day Services Manager based at a Social Services AMHS day centre in Ludlow, had undertaken a study into the support of children whose parents are receiving help from AMHS in the Ludlow area. It seemed useful to compare initial findings taking account of existing literature. His work had identified the need for:

- Further training of AMHS staff (particularly in the area of child protection) perhaps using *Crossing Bridges* (Falkov, 1998) materials.
- Closer collaboration between AMHS, CAMHS and non-statutory organisations was needed (the Day Services Manager had been particularly impressed by the work of organisations such as Homestart and Barnardos).
- The systematic record of information about AMHS users who are parents, and their children.

There is remarkable consistency between Colin's findings, the literature and findings from this project (particularly the experience of the Goldenhill Project, see below).

### **SERVICE 10 – BRIDGNORTH CMHT, SHROPSHIRE**

The CMHT based in Bridgnorth arranged for the author to visit and meet with members of his team together with the Team Manager of the Case Management Team of Children and Families, South Shropshire and Bridgnorth. The CMHT already had established links with

this team. One of the CMHNS had completed a two-week placement with the Initial Assessment Team. From this, the teams had developed an information-sharing protocol and were keen to develop further joint working. For example, CMHT staff had not previously appreciated the pressure that children's and families social workers were under to produce reports at great speed. AMHS workers are sometimes dismayed at the short notice they are given when being invited to case conferences, insights into the reasons behind this and an improved mutual understanding had been gained.

Five members of the CMHT team are trained in BFT. The team was eager to work with more families and felt more confident about involving children, and needed to receive ongoing supervision in order to maintain this.

## **SERVICE 11 – ACPC TRAINING, REDDITCH AND WORCESTER**

In April 2003, the Meriden Programme was invited to provide two training mornings to a multi-agency audience at the invitation of Worcestershire's Area Child Protection Committee (ACPC). Prior to developing the training, the author met with the ACPC Development Officer to discuss the learning needs of children's and young people's workers in relation to parental mental health. The training was then planned using some elements of *Crossing Bridges* (Falkov, 1998).

The training was well received by both groups (North and South Worcestershire), who evaluated the sessions as being of high quality generally and of high relevance to practice. This would suggest there is an unmet need for more widespread training in parental mental health for this group of workers. The session in Worcester was attended by a carer and a mental health social worker from Malvern. The carer subsequently contacted the Meriden Programme for help with finding appropriate resources for her children, whose father has a psychotic illness. The social worker asked for training in BFT and was, shortly afterwards, recruited to the BFT training programme.

A further consequence of our collaboration with the ACPC workers – the Development Officer and the Training and Development Advisor - was the help they provided with a skills development day which was organised for BFT practitioners in Worcestershire in July 2003, on the theme of 'Addressing the needs of children in families where there is an individual with a mental health problem'. In a sense, this was the mirror image of the ACPC training mornings and it was a delight to be joined by them as well as Heide Lloyd (a contributor to *Crossing Bridges* (ibid)). Heidi has developed a booklet for children where a parent is experiencing mental ill-health, which was circulated at the Meriden conference 'Working with Families – Giving People their Lives Back' in March 2003, and has resulted in an extremely good response nationally.

There would appear to be a substantial unmet need for training, both for AMHS workers in working with children (particularly children in special circumstances) and for children's and young people's workers (not solely CAMHS workers) in working with parents with mental health problems. *Crossing Bridges* (ibid) is designed to meet these complementary needs and contains some excellent and invaluable material. However, it was found that some of the materials are orientated towards a more medical model and some adaptation was necessary to make it acceptable to a multi-disciplinary audience.

## **SERVICE 12 – PRIMARY CARE FAMILY WORK AND CARERS DEVELOPMENT WORK IN MALVERN, WORCESTERSHIRE**

Two visits were made to Malvern in South Worcestershire. The first was to Malvern Health Centre to meet two 'Primary Care Family Workers'. The two part-time posts, funded by the Primary Care Trust, are held by a social worker and a CPN. Through these posts, it is hoped to provide prompt easy access to children registered with the surgery, to assess and treat children with significant mental health problems, and release specialist CAMHS and GP time whilst allowing children and families to avoid the stigma of becoming involved in 'mental health services'.

The post-holders were very proud of their achievements so far. They felt a large number of the children they saw had a parent with depression. However, they acknowledged that they had had little contact with families affected by severe and enduring parental mental health problems. Much of their contact has been with children and parents with more common mental health problems. In many ways, the posts fit the definition of PCAMHWs (see above), although they are described as Primary Care Family Workers.

Secondly, contact was made with a Carers' Development Worker based at St Anne's Orchard Day Hospital. She had attended the ACPC training session (see above) and contacted the Meriden Programme to discuss her interest in young carers. As a Carers Development Worker she has a secondary role to do with addressing the needs of young carers. She often receives enquiries from CMHT's concerned about young carers, but only has a designated half-day per week for this work. Therefore she is unable to carry out direct work with young carers, but instead uses her time to pass on information to CMHT's throughout Worcestershire. The worker has links with Worcester's Young Carers Project, which is now based within the Youth Service (but was previously part of the Worcestershire Association of Carers and funded by Social Services). Guidelines in Worcestershire state that young carers should be assessed as 'children in need'. However, there is a feeling that there ought to be a special young carers assessment, which should be a young person's version of the general carers assessment.

The worker is interested in psychosocial interventions and feels that BFT could be extremely helpful to young carers, even where the family is not affected by psychosis. This mirrors the feelings of those colleagues in YOT's and CAMHS across the region who, despite the lack of a clear evidence base, would like to see BFT used in a broader context to reduce stress in families.

## **SERVICE 13 – SOUTH WORCESTERSHIRE MOTHER AND BABY SERVICE**

The service was 're-born' in February 2002 (following its closure in 1999) to meet the needs of mothers experiencing pregnancy related mental illness. It is managed by the Specialist Mental Health Nurse and Clinical Manager of South Worcestershire's Mother and Baby Service. The aims are:

- Early identification of those at high risk of mental health problems ante/post partum.
- Specialist management of vulnerable women.
- Early and accurate diagnosis.
- Early intervention at the right level with minimal disruption to family life.

The team is exceptional for its skill mix – The manager is both an RMN and a Health Visitor while her CPN colleague is both an RMN and a midwife. The team is complemented by a Social Worker a psychiatrist and a psychotherapist. While at present the team covers South Worcestershire only the plan is to expand its staffing and its geographical area. The Mother and Baby Service is one of a range of specialist teams in Worcestershire e.g. crisis resolution, assertive outreach and early intervention (see above).

The manager told me she is looking forward to developing links with the Early Intervention service. The team already has an active training role with health visitors and midwives. The author asked, given their team's focus on vulnerable women, whether they also addressed the needs of fathers. The all-female team acknowledged that more could be done to engage fathers in the future. There is a parallel here with the Goldenhill Project (see the next chapter).

## Chapter 6

# Services Outside the West Midlands

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## **Beyond the West Midlands**

During the course of the Interfaces Project, the author also looked beyond the West Midlands, travelling to Wales to discuss these themes with CPNs at a conference in Cardiff, and to Scotland to visit an exceptional project in Glasgow which approached parents with mental health problems and their young carers in a remarkably comprehensive and creative way, worthy of close examination. What follows, therefore, is a detailed description of Goldenhill Parental Support Services.

## **Goldenhill Parental Support Services, Glasgow**

The Goldenhill parental support services emerged from the community mental health team based at the Goldenhill resource centre, run jointly by Greater Glasgow Primary Care NHS Trust and West Dunbartonshire Local Authority, serving the Clydebank area. The team is multi-disciplinary and provides care and support to clients aged between 16-65 years who have mental health problems, with the main focus being on clients with severe and enduring mental illness.

The project arose from feedback from clients at a stakeholders' day, where some clients who were also parents said they felt the services did not support them with their parenting needs and capabilities. A successful bid for £36,000 was made to the Mental Health Development Fund and a project launched in March 2000, initially for one year. One of the CMHT members, Yvonne Milne, was appointed project leader. A total of 38 service users, all of whom had children aged from 0-18 years, took part in the project, which highlighted a number of concerns among parents and gaps in the existing services. These concerns included:

- A fear of admitting to having parenting problems (linked with a fear of losing custody of the children).
- No venue for clients to meet to discuss parenting problems.
- Professionals seeing clients' problems as related to their mental health problems and not to normal, everyday living, so issues are taken out of context and become a crisis.
- The need for education and support on mental health issues for families and children, especially when the parent is in hospital.
- The need for staff education and raised awareness of services and resources available for parents.
- That initial assessments did not, as a matter of routine, take into account parenting issues for clients with severe and enduring mental illness.

In 2001, the project became an established service, with permanent Health Board funding, offering a parenting support service directly to clients on an individual and group basis. It also aims to make changes in the organisation and the culture of the community mental health services locally: in particular to the tendency either to ignore the possibility that a client might also be a parent or to see parenting difficulties as inevitably related to mental health problems. A typical example of this 'invisibility' was the comprehensive assessment form used by the CMHT at Goldenhill, in which the single question about whether the individual had dependent children was followed immediately by a question about pets,

before going on to ask: 'Who will look after your pets if you become unwell?' There was no question asking who would look after the children. One of the first changes the Goldenhill project made was to introduce a child information form that has to be completed by CMHT members when assessing all new clients. This records details of any children in the client's family and any other agencies involved with the family and children. Any parenting concerns are recorded and a note made of whether a referral to the parental support service is needed.

## **Support services**

There are four aspects to the work carried out by the parental support service:

- Close working with other agencies, particularly child care social work staff, to offer a holistic support package to parents.
- Inter-agency training to enhance understanding and improve working links between staff when dealing with issues for parents.
- Collaborative working to enhance support for parents and their families through other agencies; offering information and advice to workers dealing with people who may have a mental health problem but are not clients of the community mental health team.
- Parent support groups where group members take the lead in defining the aims, function and activities of the group.

A key part of its role is consultancy and liaison work with mental health colleagues, primary care workers and other agencies involved with its parent-clients, such as the Glasgow Health Visitors Parent Group and the local Child Protection Network Group. The project also works closely with the NCH Healthy Minds project – a local service provided through the voluntary sector children's welfare organisation NCH Action for Children. Healthy Minds specifically addresses the needs of children of people with mental health problems.

Another key aspect of the project's work is the Crossing Bridges training programme (Falkov, 1998) that it offers to child welfare and mental health colleagues in collaboration with local child care social work staff. *Crossing Bridges*, published in 1998, is a Department of Health-sponsored training resource that aims to promote inter-agency working for the benefit of parents with mental health problems and their children. It includes, for example, a basic introduction to mental health issues for staff working in children's services and a basic grounding in child welfare and legislation for mental health workers. The aim of introducing the *Crossing Bridges* training was twofold:

- To raise awareness and ensure better understanding and skills in staff working in both adult mental health and children's social services.
- To improve individual practice and how individuals work together across the specialist areas to encourage more effective collaboration for the benefit of mentally ill parents and their children.

Initially the training was provided just to team leaders and clinical managers. Subsequently two volunteers were recruited to 'roll out' the introductory module to all staff. The second module, covering relevant legislation, is currently being adapted to Scottish mental health and childcare legislation.

The parent support group has been running since January 2001 and currently has a membership of 12 parents, all with a severe and enduring mental illness and with children ranging from 18 months to 17 years in age. The group meets for two hours on a monthly basis during the school term and fortnightly during school breaks, with crèche facilities at a local community base. The group is user-led and facilitated by staff members and offers support, information and discussion on parenting matters and helps parents tap into local resources. It also organises social and educational activities for the parents and their children, as suggested by group members. It has organised events to raise money for its activities and also gets involved in the wider policy arena. When the new-build Gartnavel Royal Hospital was being planned the group put forward a proposal for a 'family-friendly' visiting area on the psychiatric ward.

Parents who have attended the project report they find it most helpful for the way it acknowledges them as parents, not just patients. They say services tend to focus on the difficulties they have related to their illness and overlook the challenges they face as parents. They particularly value the social aspects of the group, such as the organised trips with their children. Other comments from parents highlight the mutual support and opportunities to meet other parents with mental health problems as very helpful. The participants are predominantly women. A very small number are fathers and Goldenhill is working with them to make its service more 'father-friendly' and encourage more men to use it.



# Chapter 7

## Case Study

# Case Study: Using Behavioural Family Therapy in a family with young children

## Family Services

This case study highlights several 'complex' clinical dilemmas in which services would undoubtedly differ on in terms of a response. It is useful to consider these in terms of how services can learn from each other rather than act 'in parallel'.

## Introduction

What follows is an account of behavioural family therapy with a family affected by parental mental health problems. It is included to illustrate some of the concepts introduced in other parts of this report, and to show how these might be applied to, and inform, 'real-life' practice. All names have been changed to protect the family's identity.

## Anne

I had known Anne for over a year as her Community Psychiatric Nurse (CPN) before suggesting Behavioural Family Therapy (BFT). She was 31, and had a diagnosis of bipolar affective disorder. She believes she first become ill after disclosing to her parents that she had been a victim of child sexual abuse. The death of Anne's grandmother triggered a further episode of psychosis. According to Anne, she experienced a third episode of psychosis after discontinuing anti-psychotic medication. My involvement as CPN began following discharge from hospital after this third episode.

In my role as Anne's CPN, I had offered mainly individual support and had tried to promote compliance with prescribed medication. Anne was missing the support of her parents who had retired and moved away. At the time, her husband Nigel was employed but was facing the threat of redundancy. The couple had two children – Kirsty, aged 9, who attended a local school and Craig, aged 4, who was attending a local playgroup for children with special needs. Craig was described as 'hyperactive' and Anne complained frequently about the stress of managing his behaviour.

I had liaised closely with Anne's GP, who had known the family over many years. I also worked closely with the Social Services benefit's adviser, and together we successfully appealed against a decision not to grant Anne Disability Living Allowance. Our successful efforts advocating on behalf of the family's right to benefits helped cement the therapeutic relationship, as did adopting an assertive approach to resolving difficulties she experienced with prescriptions and medication reviews.

In summer 2002, I informed Anne that I was taking a new post and therefore could not continue as her CPN. Since my new post involved researching links between child, adult and family mental health we negotiated an arrangement whereby I would offer Anne and her family BFT on the understanding that the locality team provide her with a CPN and care coordinator. The family agreed and an Occupational Therapist trained in BFT (called in this case study 'Yvonne') agreed to be my co-worker, while a colleague replaced me as Anne's CPN and Care Coordinator. By this time, Nigel had been made redundant and had become Anne's full-time carer.

## Assessment

Yvonne and I met initially with Anne and Nigel to discuss the purpose of BFT and to agree who ought to be involved. Both parents felt strongly that, as the children were affected by Anne's illness, they ought to be part of the process but, from the start, there was ambivalence about if and how to involve them. Kirsty (9) was seen as less problematic. As the elder child, she was judged to have the necessary understanding and concentration to take part. Craig (4), by contrast, was seen as too young to understand discussions and likely to disrupt sessions because of his 'hyperactive' behaviour.

### **Point for Reflection – Who is involved in therapy and who decides this?**

We therefore agreed with Nigel and Anne that they would discuss BFT with Kirsty and that she would be invited to meet us. Kirsty would be asked if she would like to take part while the parents would arrange a suitable activity to occupy Craig. Initially, the parents suggested taking Kirsty out of school to take part but we explained we would be happy to meet with the family *after* school. On reflection, the parents thought this wiser, and alluded to Kirsty having existing difficulties with school work which they would not want to compound.

Following these engagement sessions we went on to carry out individual assessments with the three participating family members, and at the following session assessed the family's problem-solving abilities. Two of the individual assessments were done concurrently in the home (Yvonne interviewing Nigel while I interviewed Kirsty). Interestingly, it was only when Yvonne assessed Anne that we became aware she had married Nigel just 5 years previously and that Kirsty was her child from a previous relationship. All family members agreed, at the beginning, to sessions being tape recorded for the purpose of evaluating the therapists. My individual assessment of Kirsty was a novel experience for me, as I had never 'assessed' a nine year old before. This is, therefore, described in greater detail, before considering the situation of the other child, Craig.

### **Point for Reflection – Can young children e.g. Craig (5 years) be involved in therapy?**

## Kirsty

During her individual assessment Kirsty was extremely cooperative and seemed to enjoy the fact that we were tape-recording the session.

When discussing Kirsty's knowledge of her mother's mental health problem, I prompted her by referring to "Mum's problem". This was not clear enough so I talked about "Mum's illness" and Kirsty began to think in terms, understandably, of physical illness. She told me her mother's main problem was 'diarrhoea', that Anne "takes lots of medication" and gets "stomach cramp and feels ill when she's out". Kirsty seemed to be identifying symptoms of anxiety in her mother which, indeed, are a feature of Anne's mental health problem. When asked what caused these problems, Kirsty was very clear that they began "when Mum's Nan died", but went on to add that "Craig drives her mad all the time – he's really naughty". I reflected this back by saying that Kirsty seemed to think Anne's illness was caused partly by upsetting things that had happened in the past and partly by difficult situations in the present day. She agreed, and added: "She has mood swings."

Kirsty found it difficult to recognise any detrimental or beneficial factors except to reiterate that Craig's behaviour seemed to make her mother more stressed. Regarding the future outlook, Kirsty said she hoped her mother would get better. Her understanding of her

mother's medication was that Anne took 'diarrhoea tablets' and the side effect of these was 'tiredness'.

When asked about coping, Kirsty said her main difficulty was that: "Craig gets me into trouble ... Mum shouts at me. Mum gets angry and moody. When she sees road sweepers and bins she runs away." (Anne sometimes has delusional beliefs that waste bins will contaminate her). When asked how she felt about this behaviour, Kirsty said she thought it was 'weird'. She coped with her mother's (sometimes displaced) anger and 'moodiness' either by ignoring Craig or "getting really angry" herself. (Kirsty's own 'moodiness' was sometimes interpreted by the parents as a sign that she "takes after her mother", with the barely disguised fear that Kirsty might, herself, go on to develop a mood disorder.)

Regarding activities, Kirsty said she spent most of her time at school, reading, doing art or homework. She would have liked to spend more time swimming, or taking part in clubs, for example, singing, art or dancing clubs. She would also like to see more of her friends. For support she tended to talk to her mother at bedtime and Nigel sometimes. She disliked school and home, and was concerned about her mother, and Nigel and Craig. It seems she disliked school because she found some of the schoolwork difficult and disliked home because, at times, there was conflict between other family members.

Kirsty appeared happier when we turned to goal setting. In order to free up the thinking of adults, therapists often use phrases like "If the current problem were to go away" or "If we could wave a magic wand...." In interviewing Kirsty, I became aware that she might be too ready to believe in our ability to perform magic, so I felt I had to be more cautious in setting goals with her. Her first goal was to start learning to sing and dance within 3 months. She had done some singing at school but a problem already encountered was that her parents had said she could not join the choir because choir practice was "too late at night" and the family had no car. Kirsty (correctly) predicted that, in terms of support or conflict, Nigel might object but Anne would encourage her. For a second goal, Kirsty aimed to "get better at drawing and colouring". She felt she was already good at art and both parents would encourage her in this goal.

When asked about any other problems, Kirsty simply stated that she felt it was not fair that she would be doing things like this and not Craig. She clearly saw the goal-orientated work as an opportunity of which Craig was being deprived. I suggested that she and her parents could decide how best to share the benefits of BFT with Craig, and that the family might want to help Craig to set some goals for himself in the future. For all that Kirsty perceived Craig as someone who "gets her into trouble" (creating stress for her mother which is then projected onto Kirsty), she clearly did not want Craig to be left out. It is refreshing, as a worker used to adults' ambivalence towards BFT, to witness a child's positive embracing of the intervention. My hope, (and one shared by my co-worker Yvonne), was that Kirsty's optimism about BFT helping her achieve her goals would not end in disappointment.

**Point for Reflection – Can the use of BFT be viewed as a way of accessing and assessing the needs of children where a parent is involved with adult mental health services?**

## **Craig**

I was aware that Anne found Craig a demanding child. During my visits as a CPN I had met Craig several times and found him to be a friendly, talkative and sometimes boisterous child

who loved to play with his wooden train set. Anne had long suggested he was 'hyperactive' and I had previously spoken with the health visitor about her concerns. By the time BFT began, the parents were receiving help for Craig from a child psychologist. She saw Craig with his parents for a series of sessions at the health centre. It seemed appropriate that Yvonne and I should ask the parents' permission to meet with the psychologist so we could coordinate her work (which focused on Craig) with our own work (which focused on Anne, Nigel and Kirsty).

We met the psychologist at her office. She was interested to hear about our approach and felt it would be generally helpful to the family, complementing the work she had done regarding Craig, which was drawing to a close. It seemed she was reluctant to diagnose Craig as having any particular condition, but felt that positive, consistent parenting could ameliorate his developmental delays. She had therefore given Anne and Nigel some strategies in dealing with Craig which, she felt, would be sufficient to improve his development.

The psychologist took the view that Craig's developmental delays might well be due to the effects of Anne's illness and hospitalisations on the children. For this reason, she enquired about our impressions of Kirsty – Anne had also expressed concerns to her about Kirsty's 'moodiness'. Our view was that Kirsty was a relatively healthy child who showed no behavioural disturbances or obvious developmental delays (although the educational difficulties over which her parents expressed concern may have been somewhat overlooked). It is common practice in child and adolescent mental health to hesitate in making firm diagnoses, and to suggest changes within the family (and particularly parent-child) relationships. Anne and Nigel became increasingly frustrated by this approach, however, and were keen to be given a clear diagnosis for Craig's problems. This is understandable given that Anne had suffered more than one episode of psychosis before being diagnosed with bipolar affective disorder. Their view was, the sooner someone would diagnose Craig's condition the sooner appropriate treatment could be accessed. They therefore sought a second opinion.

The urgency for appropriate diagnosis and treatment for Craig had increased as, by the time we began BFT, Craig had started school. Nigel and Anne were very worried about his sleeping, eating and toileting, as well as his academic progress, his limited attention and concentration.

He was assessed by Speech and Language Therapist (at age 5 years 6 months). She found that Craig had "a significant delay in receptive and expressive language skills mainly due to limited attention control". She stated that his difficulties would impact on his ability to process information in the school and access the appropriate level of the National Curriculum. She suggested that his "impulsive and boisterous behaviour may also impact on his socialisation in the playground and with his peers", and recommended a number of actions for the school to implement, one of which was the use of active listening strategies such as "good sitting", "good listening" etc.

## **Formulation**

This was the formulation we arrived at after the first four engagement and assessment sessions:

Anne remains precariously well on a combination of medications but often appears

tired, irritable and unable to take a very active role in family life or the running of the household. Nigel has, since being made redundant, taken on the role of full-time carer to Anne and, in practice, does much of the housework and childcare. Both parents are extremely stressed by the behaviour of Craig and feel that health professionals do not take his problems seriously enough. Kirsty appears to be the least anxious, most positive member of the family, and generally seems to 'cause no trouble'. At times, though, she becomes the target of Anne's anger and frustration. Kirsty is said to be 'moody like her mum'.

Regarding individual goals, Kirsty wants to develop her singing and art (and is excited about the prospect of achieving these goals through BFT), Nigel wants to do more D.I.Y and spend time on his motorbike (he currently has little time away from his caring role). Anne would like to cook at least one family meal per week and explore the possibility of further study (perhaps by correspondence course).

They have agreed for the sessions to be tape-recorded and have agreed that Craig will be occupied in a separate room during BFT sessions. When assessed attempting problem solving, the family seemed able to solve problems reasonably effectively but Kirsty tended to be given little choice or encouragement to express an opinion. They all demonstrated active listening skills to some extent, but did not express pleasant or unpleasant feelings, nor did they make any requests of each other.

### **Progress of sessions**

The family was keen to learn more about Anne's illness and its treatment. We agreed that the educational sessions would take place in the dining room while Craig was left with a railway video playing in the living room - a strategy that worked well for a few sessions, with Craig apparently contented and making no attempts to interrupt. At the end of each session I would comment on how Craig had been helpful and quiet and had shown he could concentrate for a whole hour on watching a video. Yvonne and I would model expressing a pleasant feeling to Craig about his behaviour, but we noticed that neither Anne nor Nigel would spontaneously reinforce it.

### **Suicidal ideation**

Kirsty took an active part in our early discussions about bipolar illness and seemed to quickly gain a greater understanding. Anne was placed in the position of the 'expert' on her condition and gave vivid accounts of the experiences of psychosis, depression and mania. She was good-humoured about her manic episodes and Kirsty found some of Anne's experiences amusing – the family being able to laugh about Anne's delusional beliefs in retrospect. Less amusing was Anne's description of how, at times she had thought her children were not her own. Anne then went on to talk about her having felt 'suicidal'. Kirsty did not understand what this meant and the parents then glanced at each other, wondering how to explain it.

We explained to Kirsty that, sometimes, when people are feeling very low, they think about hurting themselves. Kirsty seemed to understand this but during this session became tearful. Anne and Nigel seemed unaware of how affected Kirsty was by some of the more painful content of Anne's account of manic depression, or they may have interpreted it as another example of her 'moodiness'. Yvonne and I were conscious of our responsibility to try to

make the sessions a safe and positive experience for all. We realised that, while learning about mania may be 'funny', learning about your mother's suicidal ideation may not (especially if it is linked to feeling unloved or to blame for the illness).

**Point for Reflection – Does speaking frankly about suicidal intent amount to a form of psychological or emotional abuse?**

Falkov (1998) recommends that, where children are to be actively involved, the therapists should agree with the parents beforehand what areas are appropriate to discuss. Had we had such a preliminary discussion in our engagement meeting with the parents we might well have agreed that the topics of suicide (and also Anne's history of child sexual abuse) would need to be avoided for Kirsty's sake.

To help Kirsty achieve her goal of "getting better at drawing and colouring", I had provided both children with some colouring sheets produced for World Mental Health Day. Kirsty had happily coloured these in and had helped Craig with his. I provided both children with copies of *Children have feelings* (Lloyd, 1998) – a booklet specially produced for the children of parents with mental health problems, which forms an appendix to *Crossing Bridges* (Falkov, 1998). I also lent Kirsty a copy of *The Illustrated Mum* (Wilson, 1999) – a children's novel about a woman with bipolar illness and her two young children. The book is written for '12 year olds and over' but I hoped Anne or Nigel might read some of it to her. It transpired Kirsty liked the same author's books for younger children. When I explained what *The Illustrated Mum* was about, Kirsty said, amazed: "You mean there are other families like ours?" Fredman and Fuggle (2000) have described how narratives and stories are an invaluable way of helping children by offering "a way of holding together complex and possibly ambiguous, contradictory or conflicted experiences within a connected pattern of meaning" (Fredman and Fuggle, 2000: 215).

**Point for Reflection – Are narratives and stories of value for children in terms of helping them understand complexity and what is the most appropriate way of delivering these?**

## **Domestic violence**

As we continued with the educational sessions, it emerged that Anne often hit or kicked Nigel when she was irritable. This seemed to happen on a fairly regular basis. Nigel had alluded to it in his individual assessment when he described one of the main difficulties as Anne's aggression. When it was discussed in the BFT session, Nigel seemed embarrassed and tried to laugh it off. Anne explained that she felt she could kill Nigel at times. Kirsty asked whether Anne ever felt like that towards Craig and herself. Anne tried to reassure her, but this was somewhat undermined by her saying that this was part of the reason she sometimes had to go into hospital.

Yvonne and I had detailed discussions between sessions in which we explored what our position on the family's domestic violence should be. Nigel seemed to accept Anne's aggression as part of her illness and, therefore, beyond her control. It was likely that Kirsty (and Craig) witnessed some of this violence and there was a risk that the children might, at the least, get "caught in the crossfire", if not become the target of physical violence themselves. Still, we had seen no evidence of physical aggression towards the children at this point. We decided to monitor the situation and to encourage the family to consider whether violence was tolerable under any circumstances. We had already agreed a ground rule for BFT that there should be no physical or verbal aggression within the sessions (this included avoiding raised voices or interrupting other family members) and

this had to be reinforced as inappropriate language was used on one occasion. We hoped that, if we could establish a non-violent atmosphere within sessions this might become generalised to times when family members were together without the therapists.

### **Temporary disengagement and review**

Two months into therapy, Anne had developed a chest infection that was troubling her greatly and affecting her sleep pattern. She and Nigel became very preoccupied with her physical health. We persevered with the educational sessions, sharing information about medication, and Kirsty seemed to gain a greater understanding of her mother's illness and treatment.

We were surprised, between sessions, to receive a telephone call from Anne around this time requesting that BFT be discontinued. It was unclear whether this was Anne's decision in isolation, or hers and Nigel's, but we doubted Kirsty's opinion was represented, as we knew she was very positive about the sessions and also knew (from the family assessment) that Kirsty's opinions are not generally solicited. On further questioning it became clear that both Anne and Nigel had concerns about the BFT. First, they did not feel the sessions were helping. Second, they complained that the sessions "felt too much like being at school".

We were aware that, in finding appropriate language for providing information about medication, we had had to simplify terminology so Kirsty could understand. She would often ask clarifying questions to check she had understood. The parents' understanding was greater and they may have felt frustrated or even patronised by our style. We arranged to meet with the family to discuss their concerns about the approach and were very anxious that they might disengage; despite the benefits that we felt Kirsty was gaining from BFT.

When we met with them there were a number of other concerns expressed. They felt that the use of the dining room made the sessions too formal (adding to the 'back at school' atmosphere) because we were sat round the table. We admitted that we had spent longer than planned over the educational sessions because we were allowing more time to explain terminology to Kirsty. We therefore agreed to move the sessions back to the living room so they would feel more relaxed. This raised the question of how to manage Craig. The parents said they had felt guilty about 'excluding' him from the sessions and were worried about not being able to observe him during sessions. We asked the family to suggest solutions and they decided Craig should be allowed to 'sit in'. We expressed concern that he may get bored and that they may find it hard to concentrate but they were adamant that they would like to try the sessions with Craig in the room. Finally, they objected to the tape recording of sessions, which, they felt, added to the too formal atmosphere. They seemed surprised that we agreed to all their suggestions by saying we would stop taping, and hold sessions in the living room with Craig present. We then reinforced how pleased we were with their progress on individual goals. Anne was cooking more meals, Nigel had done some D.I.Y and was going out on his motorbike and Kirsty had joined the school choir.

### **Kirsty's singing**

Originally, when the family had shared their individual goals, the parents had objected to Kirsty's wish to "start learning to sing". As Kirsty had correctly anticipated in her individual assessment, Nigel raised obstacles such as the logistics of getting her to choir practice, and their inability to afford private singing lessons. He had wanted Kirsty to change her



goal to “spending more time on homework” or “trying harder at school”. We, however, had stressed that individuals needed to set their own goals for themselves. After some discussion, Anne had suggested she could talk to Kirsty’s teacher about singing. As a result, the problem had been solved; Kirsty had joined the choir and was thoroughly enjoying it. She had also achieved her wish of joining a singing club and making some new friends. Kirsty valued this goal highly and her comment was the most powerful argument for the family to re-engage in BFT. When asked how the family sessions had helped her, she said: “It just goes to show that dreams *can* come true”.

### **Early warning signs**

After 3 months, we began work on recognising early warning signs of relapse. Since Anne has a bipolar illness this exercise had to be done twice – once to identify early warning signs of a depressive episode, then to identify those that preceded a manic episode. We used a ‘card sort’ exercise (developed by Dr Jo Smith as part of Worcestershire’s Early Warning Signs Self-Management Pack). These sessions worked well with both children ‘helping’ to sort the cards that described signs of Anne’s relapse signature. Apart from arriving at early warning signs plans for both manic and depressive episodes, this exercise brought to light four facts about the family. First, that Anne was, at the time of the exercise, already showing signs of relapse (prolonged sleep disturbance leading to irritability). Second, Craig’s presence in the room affected everybody’s ability to concentrate. Third, that Anne frequently made angry comments to –or about - Craig (e.g. “he drives me mad!” or “you’re driving me mad!” – this last comment shouted directly to Craig’s face. He responded by mimicking his mother and shouting back “You drive *me* mad!”) Fourthly, it emerged that Anne had hit Kirsty.

Having identified that Anne was showing early signs of relapse we requested of Anne’s CPN that an out-patient appointment be arranged promptly to see if symptomatic control of Anne’s sleep disturbance could be achieved by adjustments or additions to her medication. Craig’s behaviour, and his mother’s behaviour towards him, seemed to indicate that it would not be possible to continue the sessions in this way. We had some sympathy for Anne’s irritation – especially given her sleep deprivation – but it seemed obvious from this example that Craig’s ‘boisterousness’ is sometimes a direct reaction to his mother’s communication with him, which could be viewed as emotional or psychological abuse. Concerns over the welfare of the children came to a head when we learnt of the physical abuse of Kirsty.

### **Child protection, problem-solving and anger management**

During the card sort exercise Kirsty had agreed strongly that one of the statements (“I become violent towards those around me”) applied to Anne. She took the opportunity to disclose an incident (which occurred around the time of her recent 10<sup>th</sup> birthday) when Anne – who was trying to sleep in the afternoon – had come downstairs to complain that Kirsty was making too much noise. The situation had escalated and Anne had hit Kirsty in the face. Kirsty still had a mark around her mouth. We expressed our concern and suggested that we would need to discuss this further in the next session, and that we would also discuss it with Anne’s CPN and Care Coordinator. We did this (also taking the opportunity to discuss the situation in BFT supervision). The dilemma was that we did not want the family to disengage again but we had to treat Kirsty (and possibly Craig) as ‘children in need’ if not, indeed, “children who are suffering or are likely to suffer significant harm” as defined by the *Framework for the Assessment of Children in Need and their Families* (Department of Health,

2000), albeit that the risk to them might be temporary and contingent upon Anne being less well.

Yvonne informed the Duty Children and Family Social Worker of our concerns while the CPN agreed to inform Anne's psychiatrist and liaise with the school nurse. The school nurse reported back that she had met Kirsty at her previous school and had had no particular concerns but said that she would try to think of an 'excuse to have a chat' with Kirsty at school to ascertain how she was. The duty social worker checked records and found that Anne had a file, which was now closed, and there were no other concerns recorded. The incident we reported was recorded and the children and family team took no further action. Meanwhile the psychiatrist made a referral to the mental health social worker (MHSW) team. The intention was that a MHSW could visit Anne and monitor her parenting skills and the welfare of the children. When the MHSW team received the referral, they realised Anne was already attending the day centre and had a CPN and two workers (ourselves) carrying out BFT. They felt it was therefore inappropriate to offer additional input and so the case was left unallocated.

In an attempt to stay faithful to the BFT approach and, at the same time address the problem of domestic violence in the family, Yvonne and I decided (following suggestions in supervision) that we should attempt to problem-solve with the family how to manage situations where someone feels angry with another family member. The family was surprisingly agreeable to this, even though it coincided with our telling them we had shared our concerns about the violence towards Anne with other professionals. Nigel disclosed that he had himself had some individual anger management sessions with a psychologist in the past, although this had not been mentioned in his own individual assessment. He told us he came from a physically abusive family and, earlier in their relationship; he had been violent towards Anne. Anne had been brought up by 'strict' parents and so the couple's tolerance of physical expressions of anger was high. Nevertheless, with guidance from us, Anne, Nigel and Kirsty were able to problem-solve the management of angry feelings towards one another. The communication skills training which was to follow would, we hoped, help lower the emotional temperature further and encourage the safe expression of unpleasant feelings.

### **Care coordination**

After taking time out for anger management and problem solving, we completed the Early Warning Signs work to everyone's satisfaction. As far as we were aware, Anne had had no care coordination review during the 6 months of BFT and, since she was still awaiting an out-patient appointment and had still not had her medication reviewed despite showing early signs of relapse, we decided to call a professionals' meeting. The psychiatrist asked for clarification of the timing and nature of the meeting, which was attended by the day centre manager, the CPN, the consultant psychiatrist, Yvonne and I.

The meeting began with the psychiatrist questioning the need for the family to have BFT. She said she had not been informed of the concerns over Kirsty's safety and felt a risk assessment of Anne should have been completed. We asked for clarification of who the care coordinator was, since it is this person's responsibility to organise regular care reviews involving professionals and carers. Nobody identified themselves as Anne's care coordinator and so, reluctantly, her CPN agreed to take on this role. We gave an account of the BFT, its successes and its difficulties and, on balance, the psychiatrist agreed that it was very useful. A plan was agreed, therefore, whereby we would continue with BFT, in order to work with the family on communication skills and problem solving, and we would then review the situation

again. The psychiatrist also agreed to review Anne's mental state and medication.

### **Further help for Craig**

Seven months into therapy, the family reported that they felt Craig's problems were finally being taken seriously. Following the speech and language therapist's assessment, Craig was referred to a paediatrician and to a specialist community health nurse. The referral to the latter was for "Craig and his parents' need for behavioural support". The specialist community health nurse visited the family several times and was extremely concerned about Craig's hyperactivity, finding that "any attempts to distract will only work if it involves his obsessional interest in trains". She felt a four-month wait to see another paediatrician was unacceptable since Craig appeared, in her judgment, "to meet the ADHD top ratings" coupled with his mother having a bipolar disorder. She suggested that the family would be unable to cope unless Craig was prescribed medication in addition to the "behaviour modification techniques" she was offering the family. In suggesting medication to the GP, she added that both the school and the speech and language therapist supported her concerns.

Yvonne and I arranged to meet with the specialist community health nurse. We explained the BFT approach and the point we had reached, including the difficulties that we had experienced in sessions where Craig stayed in the room. On the other hand, we pointed out that Craig had on occasions been happily occupied for up to an hour during our visits. It was agreed the specialist community health nurse would reinforce the logic of Craig being offered an alternative activity during our sessions.

Around this time we detected a polarisation in the views of different professionals. From one perspective, Craig could be seen as a boisterous boy with some developmental delays and a typically 'boyish' interest in trains; from another, he is a boy with a learning difficulty and ADHD, who needs to be given a clear diagnosis, behavioural management at home and at school, and medication to make this possible.

**Point for Reflection – Does the involvement of many agencies/professionals give a better service to families and how can this be delivered as interagency collaboration – using specialist expertise in a collaborative way?**

### **Communication skills**

The family was quick to develop their abilities in communication skills and have been practising and recording their use of skills between sessions. They all agree that this has made for a more pleasant atmosphere in the home, and there have been no further reports of violence between family members. At the time of writing, our plan is to complete communication skills training, and conclude with problem solving before withdrawing. It is hoped that they will continue to monitor for early warning signs of relapse, and will go on using the knowledge and skills they have developed through BFT.

### **Continuities from childhood to adulthood**

Nigel has pointed out, on more than one occasion, that his sister's son has ADHD and he believes that it "runs in families". Nigel himself admits to having been very boisterous as a child, but also connects this to disruptions in the family caused by his father's alcoholism and violence. Anne wonders whether Kirsty will "take after her" with her 'moodiness'. Kirsty has suggested that Craig's hyperactivity might be an early manifestation of bipolar disorder. Kirsty

has also asked what the chances are of developing the illness herself. Adults receiving BFT will often think about the implications of the heredity component of major mental illness, but rarely ask directly for a straight answer to this question. As therapists, Yvonne and I found Kirsty's questions always to be precise and alarmingly relevant. The answer we gave was that one in a hundred people have this kind of illness, and children of parents with manic depression stand more chance of developing it than other people. Where children are involved in the BFT process, the need to balance realism and hope feels all the more important.

**Point for Reflection – Can adult mental health workers assess and deliver age appropriate information and interventions with children?**

### **Ending on a pleasant feeling**

At the end of a recent session on 'making a positive request', we all commented on how Craig had stayed upstairs while we had our meeting. "What do you think we ought to say to him?" I asked. Grabbing her prompt sheet from the previous session (on 'expressing a pleasant feeling') Kirsty ran upstairs. I stood at the foot of the stairs with Nigel, and we listened to Kirsty saying: "Craig, I really liked the way you played quietly in your room while we had our session. It helped us all to concentrate and it made me very happy!"

# Chapter 8

## Recommendations

# Recommendations

## 1. Working with families

- **Consideration should be given to the creation of substantive family therapist posts and liaison family therapist posts**

Consideration should be given to creating family therapist posts. Where these professionals have a high level of specialist training in family therapy and are willing to share their knowledge and skills through co-working with other team members. They should also be willing to carry out other clinical tasks such as routine and urgent assessments so as not to be seen as precious or elitist. Taking this a step further, Reder *et al.* (2000) suggest training posts be created for liaison family therapists that refine the skills of working with families and provide opportunities for research. The value of *liaison* family therapists would be that they might liaise across CAMHS and AMHS and act as a 'translator' between the differing models of family therapy (systemic and BFT) traditionally associated with the two services.

- **Staff need to develop a greater understanding of both systemic and psychoeducational models of family work**

On the same theme, workers need to become 'bilingual' in terms of having some understanding of both models of family therapy. In this way, family therapy could become a kind of lingua franca promoting communication between CAMHS and AMHS. Workers can then extend their vocabulary, as it were, beyond family therapy into a broader mutual understanding of child, adult and family mental health.

- **Collaboration in the use of psychosocial interventions (particularly BFT) with children, adults and families beyond the mental health arena should be promoted, whilst evidence should be gathered for effectiveness in these new applications**

There is a widespread impression that psychosocial interventions and BFT in particular could be extremely helpful to families, even where the family is not affected by psychosis. This view is shared by a number of carers support workers, YOTs and CAMHS workers across the region who, despite the lack of a clear evidence base, would like to see BFT used in a broader context to reduce stress in families.

- **BFT supervision needs to be readily available in all localities**

In order for practitioners to feel confident about providing BFT, BFT supervision should be readily available in all localities.

## 2. Team leadership

- **Services should aspire to truly multi-disciplinary working with truly multi-disciplinary team leadership**

Multi-disciplinary work is hampered where different disciplines remain in separate camps, providing parallel rather than integrated services. Team leaders of multidisciplinary services should have authority over all disciplines. This promotes inter-disciplinary equality and helps ensure that onerous tasks (such as the provision of a DSH duty service) are equitably shared between disciplines.

### 3. Therapeutic setting - clinic or community?

- **The appropriateness of providing interventions either in clinics or in clients' homes should be considered, as well as the extent to which services should reach out to clients and their families**

A common criticism of CAMHS by AMHS is that it is over-reliant on a clinic-based approach. The concept of assertive outreach is not practiced in CAMHS generally. If patients fail to attend for appointments then they may be considered not motivated enough to need the service. This inflexibility can be an obstacle to joint-work (e.g. opportunities for family therapy co-working across BFT and systemic models may fail because of inflexibility over clinic times).

Ironically, mental health nurses in CAMHS still tend to describe themselves as 'CPNs' even though they often do little community-based work. Services might consider how this fits with the remit of the PMHW role? It is acknowledged, for example, that systemic family therapy may require special facilities. However, there is a balance to be struck between a primary care/outreach/community orientation and clinic-based work. This tension may cause difficulties when considering collaboration between CAMHS and EI services, since the latter practice an assertive outreach model.

### 4. Inter-agency working

- **The good will and expertise to be found in the youth and education services and non-statutory organisations should be built upon, and opportunities sought for collaboration between these agencies and specialist mental health services**

Organisations like The Young People's Health Project are keen to explore how they can consult with young people on mental health. Such projects illustrate how there is energy within the youth and education services for engaging in mental health promotion activities with children and young people. It would be helpful if CAMHS, Early Intervention and Young Carers services could develop their collaboration with such groups in order to optimise their effectiveness in tier one/early intervention/mental health promotion.

Closer collaboration between AMHS, CAMHS and non-statutory organisations was needed (organisations such as HomeStart, Barnardos and NCH provide invaluable services and often 'plug gaps' between statutory services).

### 5. Staff development

- **There is a need for further professional development for both CAMHS and AMHS**  
There would appear to be a substantial unmet need for training, both for AMHS workers in working with children (particularly children in special circumstances) and for children's and young people's workers (not solely CAMHS workers) in working with parents with mental health problems. *Crossing Bridges* (Falkov, 1988) is designed to meet these complementary needs and contains some excellent and invaluable material. However, it was found that some of the materials are orientated towards a more medical model and some adaptation was necessary to make it acceptable to a multi-disciplinary audience.

Greater use of experiential placements/'exchanges' could be made between children's and AMHS (as piloted in Bridgnorth). These would seem to promote mutual understanding and greater confidence among adult workers in working with children.

BFT workers feel safer working with children in families where they have good links with Children and Family Teams.

## 6. Invisibility

- **Services should address the needs of fathers as well as mothers, when considering parental mental health**

Both Worcestershire's Mother and Baby Service and the Goldenhill Project acknowledged that, despite the fact that men may seem conspicuous by their absence in the cases they deal with, more could be done to engage them. Fathers are affected by parental mental health as well as mothers and can be the main carers in a family. It is important that they are supported so that children can be buffered from the effects of taking on excessive caring responsibilities.

- **AMHS workers need to systematically record information about AMHS users who are parents, and their children.**

A crucial step in the process of making children 'visible' is simply to ask about them, and record basic information on them. This is highlighted by both *Crossing Bridges* (ibid.) and the experience of the Goldenhill Project as being central to good practice in this area.

- **Identifying and offering help to young carers should not be seen as solely the responsibility of Young Carers Projects but of all professionals who come into contact with these young people and their families**

One response to the growing demand on Young Carers Projects would be to narrow the definition of young carers to those providing only "regular and substantial care" (the phrase used in the Carers (Recognition and Services) Act, 1995). A better response might be to try to share the task through collaboration between different agencies and workers. For example, 'tier one' workers, PCAMHWs, CAMHS workers and AMHS workers visiting families are all well placed to identify young carers and put them in touch with local young carers' projects.



# Chapter 9

## References

## References

Aldridge J, Becker S. (2003) *Children caring for parents with mental illness: perspectives of young carers, parents and professionals*. Bristol: Policy Press.

Aldridge, S. and Stuart, A. (1998) *The Willow Scheme: an innovative project offering befriending support to young carers living with a severely mentally ill relative*. Presentation at National Children's Bureau Conference on 'Mentally Ill Parents and their Children', London.

Bassett, H., Lampe, J. and Lloyd, C. (1999) Parenting: Experiences and feelings of parents with a mental illness. *Journal of Mental Health*. 8 (6), 597-604.

Bruner, J. (1990) *Acts of Meaning*. Cambridge, Mass: Harvard University Press.

*Children Act 1989* (1989) London: HMSO.

Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*. London: Department of Health.

Department of Health (2000) *The NHS Plan*. London: the Stationary Office.

Department of Health (2001) *The Journey to Recovery – The Government's vision for mental health care*. London: Department of Health.

Department of Health (2002) *Developing services for carers and families of people with mental illness*. London: Department of Health.

Duncan, S. and Reder, P. (2000) Children's experience of disorder in their parents. In: Reder, P., McClure, M. and Jolley, A. (eds.) (2000) *Family matters: interfaces between child and adult mental health*. London: Routledge.

Edwards, A. and Smith, P. (1997) Young carers and their parents with long term psychiatric disorders. In: *Report of the 12<sup>th</sup> Annual Michael Sieff Foundation Conference 'Keeping Children in Mind: Balancing Children's Needs with Parents' Mental Health'*. Michael Sieff Foundation.

Engquist, M.L. (1998) Siblings of psychotic persons: reactions and influence on their network. *Human Systems*, 9, 15-20.

Falkov, A. (1996) *Study of Working Together 'Part 8' reports. Fatal Child Abuse and Parental Psychiatric Disorder: An Analysis of 100 Area Child Protection Committee Case Reviews Conducted under the Terms of Part 8 of Working Together under the Children Act 1989*. Department of Health.

Falkov, A. (ed.) (1998) *Crossing Bridges: Training Resources for Working with Mentally Ill Parents and their Children*. Department of Health.

- Falloon, I.R.H., Boyd, J.L., McGill, C.W., Williamson, M., Razani, J., Moss, H.B., Gildreman, A.M. and Simpson, G.M. (1985) Family management in the prevention of morbidity of schizophrenia. *Archives of General Psychiatry*, 42, 887-896.
- Fredman, G. and Fuggle, P. (2000) Parents with mental health problems – involving the children. In: Reder, P., McClure, M. and Jolley, A. (eds.) (2000) *Family matters: interfaces between child and adult mental health*. London: Routledge.
- Garley, D. Gallop, R. Johnston, N. and Pipitone, J. (1997) Children of the mentally ill: a qualitative focus group approach. *Journal of Psychiatric and Mental Health Nursing*, 4, 97-103.
- Gillam, T. (2002) *Reflections on Community Psychiatric Nursing*. London: Routledge.
- Hadley, R. and Clough, R. (1996) *Care in Chaos: Frustration and Challenge in Community Care*. London: Cassell.
- Health Advisory Service (1995) *Child and Adolescent Mental Health Services: Together We Stand*. London: HMSO.
- Herbert, M (2000) *Parenting skills interventions* in Reder, P., McClure, M. and Jolley, A. (eds.) (2000) *Family matters: interfaces between child and adult mental health*. London: Routledge.
- Landau, R., Harth, P., Othnay, N. and Sharfhertz, C. (1972) The influence of psychotic parents on their children's development. *American Journal of Psychiatry*, 129, 70-75.
- Laurance, J. (2003) *Pure Madness: How fear drives the mental health system*. London: Routledge.
- Leff, J. and Vaughn, C. (1985) *Expressed Emotion in Families*. New York: Guilford.
- Reder, P. and Lucey, C. (2000) The impact of children on their parents. In: Reder, P., McClure, M. and Jolley, A. (eds.) (2000) *Family matters: interfaces between child and adult mental health*. London: Routledge.
- Lloyd, H. (1998) Children have feelings In: Falkov, A. (ed.) (1998) *Crossing Bridges: Training Resources for Working with Mentally Ill Parents and their Children*. Department of Health.
- Maitra, B. and Jolley, A. (2000) Liaison between child and adult psychiatric services In: Reder, P., McClure, M. and Jolley, A. (eds.) (2000) *Family matters: interfaces between child and adult mental health*. London: Routledge.
- Mari JJ, Adams CE, Streiner D. (1997) Family interventions for schizophrenia. In Adams CE, De Jesus Mari J, White P, eds. *Schizophrenia Module of the Cochrane Database of Systematic Reviews*. Oxford: Update Software/The Cochrane Collaboration.
- Macdonald, W. (2002) Child and Adolescent Mental Health Services – challenging terrain *HCPJ*, Oct 2002: 2-6).

Meltzer H, Gill B, Petticrew M, Hinds K. (1995) *The prevalence of psychiatric morbidity among adults living in private households*. London: OPCS.

Pinsof, W.M. and Wynne, L.C. (1995) The efficacy of marital and family therapy: an empirical overview, conclusions and recommendations. *Journal of Marital and Family Therapy*, 21, 585-613.

Pound, A. (1996) Parental affective disorder and childhood disturbance. In: M.Gopfert, J. Webster and M.V. Seeman (eds) *Parental Psychiatric Disorder: Distressed Parents and their Families*. Cambridge: Cambridge University Press.

Reder, P., McClure, M. and Jolley, A. (eds.) (2000) *Family matters: interfaces between child and adult mental health*. London: Routledge.

Rutter, M. and Quinton, D. (1984) Parental psychiatric disorder: effects on children. *Psychological Medicine*, 14, 853-880.

Sands, R. (1995). The parenting experience of low income single women with a serious mental disorder. *Families in Society*, February, 86-95.

Schachnow, J. (1987) Preventive intervention with children of hospitalised psychiatric patients. *American Journal of Orthopsychiatry*, 57, 66-77.

Wilson, J. (1999) *The Illustrated Mum*. London: Doubleday.

# Chapter 10

## Appendices

# APPENDIX 1 - GLOSSARY

## Key to Acronyms

ABC	Access, Booking and Choice Project (a NIMHE initiative)
ACPC	Area Child Protection Committee
ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Service
ASD	Autistic Spectrum Disorder
BFT	Behavioural Family Therapy
BSMHT	Birmingham and Solihull Mental Health NHS Trust
CAMHS	Child And Adolescent Mental Health Service
CMHN	Community Mental Health Nurse
CMHT	Community Mental Health Team
CPA	Care Programme Approach (Used in AMHS)
CPN	Community Psychiatric Nurse
CPNA	Community Psychiatric Nurses Association
DBT	Dialectical Behavioural Therapy
DSH	Deliberate self-harm
EI	Early Intervention in Psychosis
NIMHE	National Institute for Mental Health in England
NSPCC	National Society for the Prevention of Cruelty to Children
OCD	Obsessive Compulsive Disorder
PCT	Primary Care Trust
PMHW	Primary Mental Health Worker
PCAMHW	Primary Care Child And Adolescent Mental Health Worker
PCMHW	Primary Care Mental Health Worker
RMN	Registered Mental Nurse
YOT	Youth Offending Team

## APPENDIX 2 QUESTIONNAIRE 1 (AMHS)



### Meriden CAMHS/AMHS Interfaces Project

November 2002

#### Questionnaire to examine current practice within the West Midlands

**NB.** In the following questions, Service Users = persons currently receiving a service and experiencing serious mental health problems. Dependent children = children from 0-17 years.

*Please circle appropriate responses or write in the space provided, where appropriate.*

1. In relation to service-users on your caseload/with whom you have contact, do you know whether any have dependent children?

Yes

No

2. Looking more closely at your caseload or current involvement with service-users can you identify whether any of them are parents of dependent children?

Yes

No

3. **Roughly** what percentage of your service-users are parents?

0-24%

25-49%

50-74%

75-100%

4. Does your organisation have a formal mechanism for recording the above information?

Yes

No

Don't know

If yes, give details:

---

---

5. Do you think this information would be useful/relevant to collect?

Yes

No

6. Do you have interaction with these children?

If yes go to 6a

If no go to 6b

- 6a. How would you characterise your usual interaction with these children?

- i. Peripheral, in-passing acknowledgement, e.g. saying hello
- ii. Opportunistic therapeutic intervention, e.g. if they are in the room
- iii. Planned, purposeful involvement with therapeutic intervention
- iv. Other, please specify

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6b. What do you consider to be the main reason for not being able to have contact with these children?

- i. Not seen as appropriate by clinician
- ii. Not seen as appropriate by service-user/permission not given
- iii. Visits occur when children are not at home (e.g. at school)
- iv. Other, please specify

---

---

7 What kind of concerns have you / might you have about a service-user's child(ren)?

Please list 3 if possible:

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_

8 How have you / might you address these concerns?

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_

9 With regard to the concerns you have just listed, which professionals or agencies would you be most likely to liaise with?

You may wish to consult with the list below –

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_

- |  |                               |
|--|-------------------------------|
| Clinical supervision                     | BFT supervisor                |
| Parent's adult key worker                | Mental Health Social Worker   |
| Child & Family Social Worker             | Family Doctor (GP)            |
| Child Protection Team (ACPC)             | Early Intervention Service    |
| Child & Adolescent Mental Health Service | Youth worker                  |
| Child's School Teacher                   | Service-user's partner/spouse |
| Parent's Psychiatrist                    |                               |

10 How confident do you feel about working with these children?

Totally      Quite confident      Not very      Not at all

11 What concerns do you have with working with these children?

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_



12 Does your organisation recognise the need for training in this area?

Yes

No

13 Is there a professional group specialising in working with children with whom you have good links and with whom you can share support and advice across the adult/child interface? If so, please identify:

---

---

14 Is it possible for me to contact this person to get a CAMHS perspective of interface practice?

Yes

No

Not applicable

15 Please use the space below to mention any other relevant points:

---

---

---

---

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Trust: \_\_\_\_\_

Thank you again for taking the time to complete this questionnaire.

**Please return completed questionnaires to:**

Tony Gillam, Project Worker  
CAMHS/AMHS Project  
The Meriden Programme, Academic Unit, 71 Fentham Road,  
Erdington, Birmingham B23 6AL



6a. How would you characterise your usual interaction with these parents?

- v. Peripheral, in-passing acknowledgement, e.g. saying hello
- vi. Opportunistic therapeutic intervention, e.g. if they are in the room
- vii. Planned, purposeful involvement with therapeutic intervention
- viii. Other, please specify

---

---

6b. What do you consider to be the main reason for not being able to have contact with these parents?

- v. Not seen as appropriate by worker
- vi. Not seen as appropriate by children/young person /permission not given
- vii. Contacts occur when parents are not available (e.g. at work, in hospital)
- viii. Other, please specify

---

7. If you had any concerns about a parent with a mental health problem, which professionals or agencies would you be most likely to liaise with?

You may wish to consult with the list below –

- iv. \_\_\_\_\_
- v. \_\_\_\_\_
- vi. \_\_\_\_\_

Clinical supervisor	Parent's adult key worker
Mental Health Social Worker	Child & Family Social Worker
Family Doctor (GP)	Child Protection Team (ACPC)
Parent's partner/spouse	Parent's Psychiatrist
Parent's Community Psychiatric Nurse	Other (please state)

8. How confident do you feel about working with parents with mental health problems?

Totally      Quite confident      Not very      Not at all

9. What concerns do you have about working with these parents?

- iv. \_\_\_\_\_
- v. \_\_\_\_\_
- vi. \_\_\_\_\_

10. Does your organisation recognise the need for training in this area?

Yes      No

11. Do you regularly discuss interface issues with your local adult mental health service and is there a particular person with whom you liaise? If so, please identify:

---

---

12. Roughly what percentage of the children/young people with whom you work are, in your view, likely to need specialist adult mental health services as they get older?

0-24%

25-49%

50-74%

75-100%

13. What sorts of difficulties are these children/young people most likely to be experiencing?

You may wish to consult with the list below –

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_

autistic spectrum disorder  
ADHD  
psychosis  
deliberate self-harm

Aspergers syndrome  
depression  
eating disorder  
other (please state)

14. How easy do you feel it will be for these children to make the transition from services for children/young people to specialist adult mental health services?

Very easy

somewhat easy

somewhat difficult

very difficult

15. Please use the space below to mention any other relevant points:

---

---

---

Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Employing organisation: \_\_\_\_\_

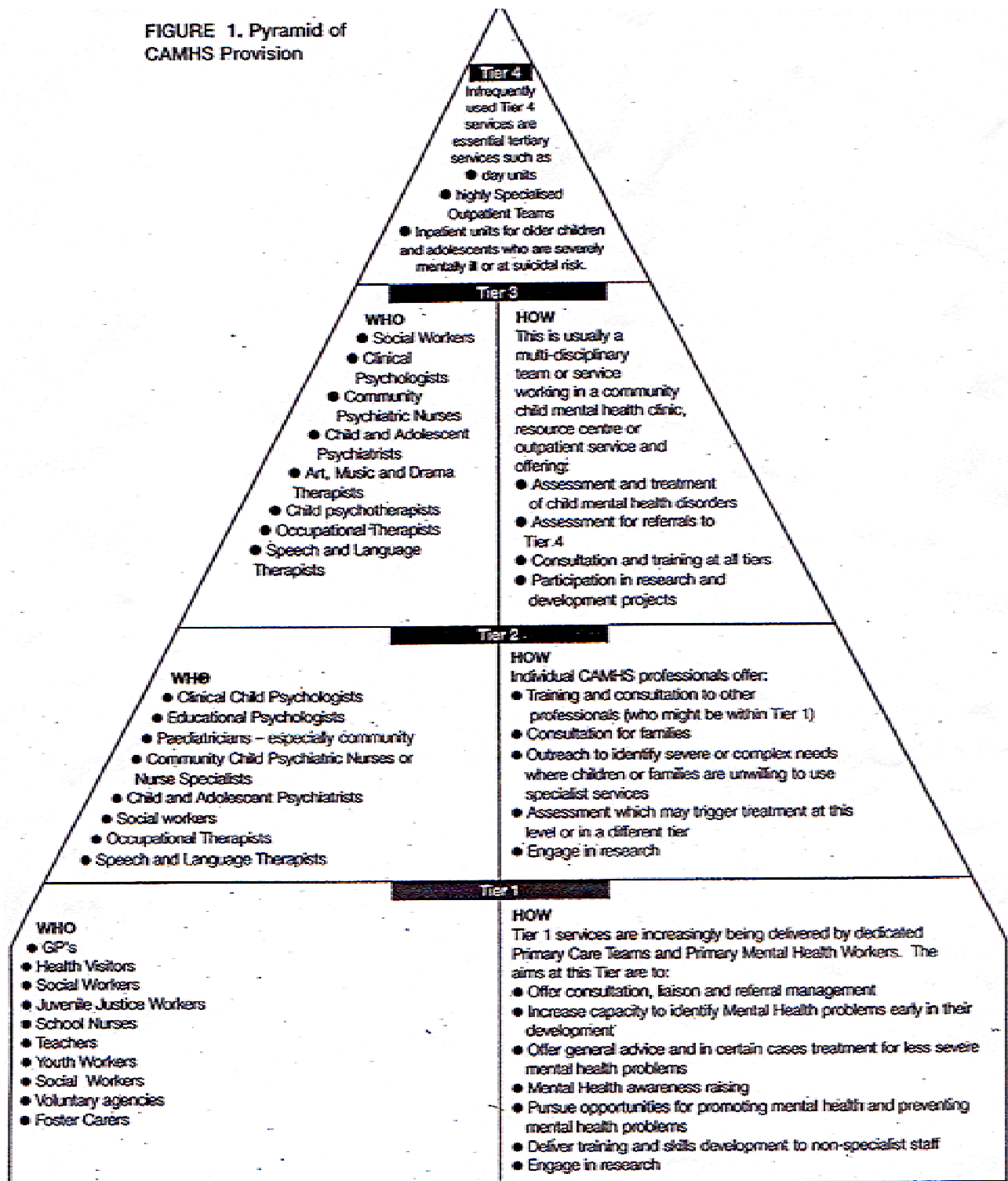
Thank you again for taking the time to complete this questionnaire.

**Please return completed questionnaires to:**

Tony Gillam, Project Worker,  
The Meriden Programme, Academic Unit, 71 Fentham Road,  
Erdington, Birmingham B23 6AL

# Appendix 4 - Pyramid of CAMHS Provision

FIGURE 1. Pyramid of CAMHS Provision



Source: The 4 Tier model for CAMHS was originally advocated by the Health Advisory Service (1994). This adaptation is based on the comprehensiveness of provision aspired to in current local CAMHS Strategies within the West Midlands.

Effective use of Tier 4 provision is dependent on the development of care pathways, led by local CAMHS teams. These need to be designed to ensure timely referral to Tier 4 of appropriate cases, with local involvement both in the process of admission and in care planning to facilitate the earliest possible discharge with support from local services.

# Appendix 5

## A Care Pathway for the transition from CAMHS to AMHS

