

Catching Children as They Fall: Mental Health Promotion in Residential Child Care in East Dunbartonshire

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This article will outline the first years of a joint project to develop a dedicated mental health service for looked after and accommodated children, which was developed between residential child care managers in East Dunbartonshire and the North Glasgow Community Adolescent Mental Health (CAMH) team. It will start by describing the events that led up to the setting of the project, and go on to outline the project itself. It will conclude with a discussion of some of the philosophical underpinnings of the project and suggestions for future developments.

Beginnings

The joint initiative 'Open Door' had its genesis in 1997, in discussions between a consultant psychiatrist from the Adolescent Psychiatry Directorate of the Glasgow Primary Care Trust and senior staff from East Dunbartonshire Social Work Department. At that time, a number of factors had come together to highlight the need for, and the real possibility of developing, a dedicated mental health provision for young people growing up within the care system.

In 1997, East Dunbartonshire was one of the pilot authorities chosen to implement the 'Looking After Children in Scotland' materials and the system of care planning which underpins them. This system focuses critically upon the outcomes experienced by looked after and accommodated young people, and links these to their experience of day-to-day care. It asserts that if the detail of care can be improved and better planned, made more to resemble the care experienced by young people growing up at home within their families, then the outcomes for looked after and accommodated young people would be more likely to resemble those enjoyed by the general population (Jackson & Kilroe, 1996; Ward, 1995).

It was recognized that the outcomes associated with being looked after and accommodated were - and continue to be - deeply discriminatory in every area from educational failure, through homelessness and offending, to economic exclusion in later life. Of particular concern were the outcomes experienced by these young people in the area of mental health. Care leavers were over-represented in adult psychiatric admission, more likely to become addicted, to be depressed, to harm themselves or to commit suicide. A number of studies, both locally in Glasgow and nationally, investigated the incidence of mental health problems among looked after and accommodated children.

An influential study in Oxford indicated that mental health difficulties were identified as present in over 60 per cent of the looked after and accommodated population, as opposed to between 10 and 20 per cent of the general population of adolescents. There was an alarmingly high incidence of over 90 per cent identified for young people accommodated in residential care. Many of these young people had more than one presenting difficulty:

‘Adolescents in the care system showed particularly high levels of psychiatric disorder compared with adolescents living with their own families. Not only did they suffer from serious psychiatric disorders, notably, major depressive disorder; they also showed high levels of comorbidity, reflecting the complexity of these adolescents’ difficulties. One of the most worrying findings was that a significant number were suffering from severe, potentially treatable psychiatric disorders which had gone undetected’. (McCann et al, 1996, p. 1530)

Looked after and accommodated children often have poor access to medical help, and especially to specialist mental health services (Chetwynd & Robb, 1999). Furthermore, residential care staff working closely with looked after young people who displayed actual or embryonic mental health difficulties felt undervalued, under-trained, marginalised and quite severely stressed themselves (Robinson et al, 1999). A Scottish survey that examined the experiences of young people within the care system found high levels of distress, an absence of specialist mental health services, and a clear sense that young people felt that nobody was listening (Friday, 1998). The voices of accommodated young people speak powerfully throughout this study, demanding that social work and health professionals recognise their distress and neglect, and their right to services to ensure their mental, emotional and psychological welfare into adulthood. The increased risk of developing a mental health disorder that occurs during adolescence for the general population appears to be considerably more increased for those who are received into care. This may be due to a number of predisposing factors present before young people cross the threshold into care, including: hereditary factors; intra-uterine insults such as maternal alcohol abuse; birth trauma; traumatic early experience; chaotic and inconsistent parenting; and experiences of abuse, including sexual abuse.

Nearly all will have feelings of separation and loss, and many will show signs of an attachment disorder. Over and above these factors, however, there may be something specific to the experience of being cared for away from one's family, especially in a group setting, a care home or residential school, which pushes a young person strongly towards poor mental health in adulthood:

'Unfortunately some young people still experience the 'care system' as one that seems specifically designed to maximise their chances of suffering from a mental health problem'. (Friday, 1998, p. 17)

The shortcomings of residential child care in Scotland and the dangers posed to children and young people growing up away from their families have been well recognized (Skinner, 1992; Kent, 1997). This has led to initiatives aimed at preventing multiple placement breakdowns, a move from institutional to more domestic care settings, and ensuring safer environments and safer staff selection. Similarly, the major NHS thematic Review of Child and Adolescent Mental Health Services published as *Together We Stand* (Health Advisory Service, 1995), highlighted the need for better co-ordinated, more accessible and more integrated services for young people, especially those at greatest risk of mental ill health in later life. Its advice to those commissioning services was direct and simple: young people need to be listened to. Agencies, especially the major health, social work and education agencies need to know one another better, to learn from and respect their respective cultures and practice, and to address the issues jointly. Services should be made more accessible, user-friendly, and with a single point of entry. Critically, the tiered model proposed by the Review insisted that identification, assessment, and intervention happen earlier, at a lower level, and that the staff who deal directly with young people (at so-called Tier 1) are better trained and supported and their work is valued and legitimized.

Development of a Specialist Service

In 1997, East Dunbartonshire had one medium-sized children's unit of ten beds, located within the grounds of a national secure facility. The authority's Residential Child Care Strategy proposed the closure of this unit and the development of a group of four small domestic houses accommodating no more than four children and young persons each. A commitment to improve the mental health prospects for looked after young people was shared by both key Children and Families managers, particularly the head of service, and the local Community Adolescent Mental Health (CAMH) team, particularly the consultant adolescent psychiatrist. It was believed that small domestic settings might provide a more therapeutic milieu. Within the ethos of 'Looking After Children', with its focus on outcomes and their relationship to the detail of day-to-day care, practical advice, support, consultation and clinical intervention

from the specialist mental health service might be added to the toolkit available to social work staff, particularly the frontline residential staff and managers.

Initially the CAMH team offered one half-day clinic a month, within the ten-bedded unit, with the consultant and a member of his team, usually a clinical psychologist or a nurse therapist. This time could be used, for instance, for face-to-face appointments with young people, with or without their carers, or for advice and consultancy to social workers and residential care staff wishing to discuss concerns about individual young people. It is important to stress that it was social work staff who were in charge of this clinical time; the clinical team made themselves available to be used in whatever way was felt to be most useful. This provided crucial ingredients for the future success of the subsequent project, namely an ethical stance of mutual respect and trust. This meant that the (informal) expertise of frontline care staff, who knew the children better than any other professional, was particularly valued by the clinical team, as well as recognizing that there would be many situations where nobody was an expert and one would have to puzzle out solutions together as best one could. Paraphrasing the French moral philosopher Levinas, it was 'taking the other as point of departure', instead of oneself. This service quickly became an established and highly regarded resource for the whole children and families team, its availability and impact being also welcomed by school guidance staff, educational psychologists and by the Children's Panel.

The opportunity to develop the initiative further came in 1999, through the chance of substantial one-year funding from the Mental Health Development Fund. On the back of good working relationships, it was possible to put together quickly an ambitious proposal which was eventually funded in full. This enabled the establishment of a small, full-time team of a clinical psychologist, a social worker, an assistant psychologist, and administrative support. To oversee, structure and support the initiative, a Steering Group was set up, with a wide representation from the professional community. It had representatives from Social Work, the Community Adolescent Psychiatric Service, Greater Glasgow Health Board, East Dunbartonshire Education and Psychological Services, the MRC Social and Public Health Services Research Unit at the University of Glasgow, the Scottish Executive (an 'empty' chair, but they were sent the minutes) and Who Cares? Scotland. The original funding also included detailed external evaluation of the initiative, commissioned from Scottish Health Feedback.

This development of the specialist service coincided with the closure of the ten-bedded unit and the movement of staff and young people to three very small residential units. This presented both opportunities for improvement in the day-to-day quality of care, but it also posed significant challenges for staff and young people who were used to much more institutional settings and the

practices that grow from them. The central tenet of the joint initiative had always been that the skills, experience and insight available to, and identified as the province of, the mental health professionals working in specialist child and adolescent psychiatry departments had, in some way, to be made available and translatable into practical tools for front-line care staff and managers. This implied that the care staff had to become familiar and comfortable with operating in areas normally reserved for 'high status' child mental health professionals. Likewise the mental health professionals had to acknowledge and value the fact that residential care staff possessed considerable informal knowledge, based both upon their own understanding of human psychology and their intimate knowledge of the details of young people's lives. It was thought that a substantial impact might be made on the mental health of the young people by providing more support for residential care workers. This central conviction, that work carried out through those involved in directly caring for young people is at least as valuable, if not more valuable, than direct clinical work with young people themselves, is increasingly supported by research (Dyke, 1987; Hay, Leheup & Almudevar, 1995; Arcelus, Bellerby & Vostanis, 1999; Baker & Duncan 2000; Cottrell et al, 2000). The point is made well by Bryce:

'... compared to the number of people working alongside young people day in, day out, sticking with them and sticking up for them... the part played by those of us who work in very specialised services is relatively small'. (Bryce, 1997, pp. 181-2)

In the first year of its operation, the initiative, now named 'Open Door', offered a wide range of services to young people, front-line care staff, social workers and the Children and Families service as a whole. These included: assessments of individual young people and follow-up clinical work; consultations to care staff and social workers about individual young people; consultations to staff teams about whole unit issues; inputs to Looked After Children reviews, research and audits; and training seminars for front-line field and residential staff. Over the year, a total of 176 consultations were offered, 102 assessments or clinical appointments given, and 13 training seminars delivered. In addition, six residential staff went on a custom-made intensive training course in psychoanalytical approaches to child development, delivered by the Scottish Institute of Human Relations.

Evaluation

The feedback from young people, care staff, fieldwork staff and other professionals who had contact with the service was overwhelmingly positive. This was borne out by an independent evaluation undertaken by Scottish Health Feedback for Greater Glasgow Health Board. Their report emphasised the

importance of the ease of access to the service. It highlighted the practical support it had brought to front-line staff and the changes it had brought to their day-to-day practice. Staff were more confident and skilled operating in areas that had previously been seen either as threatening, or even as falling within the domain of work previously regarded as properly belonging to a 'high status' professional. Critically, the process of being involved on a daily basis with mental health professionals and thinking about mental health issues allowed front-line staff to work through some of their own anxieties about working with needy and disturbed children.

The psychodynamic ways of working by the mental health team focused on providing an environment where staff were supported in thinking about the issues that made them feel anxious, rather than having to act them out. For instance, rather than getting angry with a child and then rejecting them, they were supported in thinking about why they felt angry in that particular situation, with that child, and about just what might be going on, including the possibility that the child might have engaged the staff member in re-enacting a situation of a parent rejecting a needy and frightened child. Such work facilitated residential care staff to manage the broader anxiety born of the move from institutional models of practice to smaller scale, but also more intimate, models, where it was more difficult for them to avoid working with disturbed and very needy children who often made the staff feel bad. Such children, some of whom had suffered terrible abuse, at times could only communicate inner distress by a primitive process of trying to make a staff member working with them feel, inside them, some of the pain and confusion that the child her or himself suffered but was unable to put into words, and therefore could not work through by thinking and talking about it. What was required in such situations was for staff members to try to think about, and put into words, the distress generated inside them by working with a particular child.

An important component of the work here was to support a way of working where staff were encouraged to puzzle and think about what was going on without always having to have an answer, to have the child in mind, and to come up at times with surprising insights. This supported the authority of the front-line care staff group who, when working in large institutions, had been used to a more hierarchical way of working where definitive answers to problems were given by people in authority, but in a way that was not always in tune with what was happening on the ground. This was particularly pertinent in the looked after environment, where the high prevalence of attachment difficulties meant working with acting out children who, at times, made any kind of thinking very difficult. Not thinking about the inner distress of a looked after child could leave such children feeling even more rejected and therefore even more likely to act out their distress.

None of the front-line staff saw the mental health service primarily or exclusively as being about the treatment or management of presenting problems, although they valued the practical insight and support that allowed them to manage young people's care on a daily basis. All saw the process as a longer-term intervention that would impact on the outcomes for young people in later life.

Consolidation

With the ending of Mental Health Development Fund monies in April 2001, the initiative retrenched and consolidated. Permanent funding for both the clinical psychologist post and the social worker post were identified from within the budgets of both the Primary Care Trust and Social Work Department, initially as only half-time equivalents. By this time both health and social work were deeply committed to the joint project and to the priority of looked after and accommodated young people and their mental health needs. Furthermore, 'Open Door' has evolved to become an ongoing and vital component in shaping an expanded service across Glasgow for looked after young people by Greater Glasgow Health Board. The significant expansion of resources for general adolescent mental health, set out in the Greater Glasgow Health Board Joint Strategy for Child and Adolescent Mental Health, have seen the 'Open Door' service team return to a full-time complement of a clinical psychologist, a social worker and administrative support, housed in dedicated premises in Bearsden.

It is planned to open consultations to school guidance staff, and to extend the service to young people in other care settings, such as foster care and residential schools. If resources permit, it may be possible to extend some aspects of the service, principally clinical psychological input, to the broader group of young people looked after at home in East Dunbartonshire. However, it is within the authority's children's units, working closely with the front-line teams of care staff, that the principal focus and impact of the service will remain.

The external evaluation by Scottish Health Feedback was continued on a reduced basis into 2001-2 and the results of that further evaluation are currently awaited. The original steering group has been consolidated and expanded to include representation from the community paediatric service and from 'the Big Step', the major Social Inclusion project focused upon care leavers within the Greater Glasgow Health Board area. A major current focus is to develop better longer-term evaluation tools and techniques with which to investigate the impact of services such as 'Open Door' on the outcomes experienced by young people as they move on from care into adulthood and independence. We need to know if, and how, such interventions can make a difference, and a large-scale study which might begin to address this question is being planned.

Finally, the development of a joint approach to the mental health needs of young people in residential care in East Dunbartonshire has been about a 'learning approach' to the way in which agencies - with their own priorities, cultures and practices - can come together to promote an integrated approach to the care of children in particularly difficult circumstances. Such democratic dialogue, which has allowed the participants to think and talk about the complexities of feelings engendered by working with looked after and accommodated children as they are growing up, has been vital, not just in terms of keeping the staff psychologically alive, but also because it might allow the looked after children themselves to imagine a different future for themselves. As a result, creativity, and seeking ways of facilitating this, have been recurrent themes throughout the project.

The process of developing a service dedicated to securing better mental health outcomes for young people in East Dunbartonshire's care has been as much about 'Why?' and 'Because?' and 'If Not?', as about 'How?'. This has been a form of action research (Reason, 1994), where valuing and respecting looked after young people and the adults who try and help them grow up in a healthy way has been more important than measuring and analyzing the scientific outcomes of the project. What has been central to the process, and shared from the outset by all the health and local authority players, is the conviction that by intervening and healing young people as they pass through our system, we must be helping them towards better futures. We must catch children and young people as they fall.

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