Mindful Care: The pilot of a new mental health service for young people who are looked after away from home in Moray.

Jenny Makinson
Trainee Clinical Associate Psychologist
NHS Grampian Child and Adolescent Mental Health Service, Moray

Christopher Wiles
Consultant Clinical Psychologist
NHS Grampian Child and Adolescent Mental Health Service, Moray

Debbie Jones
Systemic Psychotherapist
NHS Grampian Child and Adolescent Mental Health Service, Moray

Sheila Erskine
Service Manager
Action for Children, Moray.

Introduction

It is well documented that children and young people who are looked after away from home have significantly high rates of mental health problems coupled with poor psychological adjustment and general levels of emotional wellbeing (McCann et al., 1996; Minnis & Devine, 2001; Minnis et al., 2001; Hill & Watkins, 2003; Meltzer et al., 2004; Rodrigues, 2004; Ford et al., 2007). A range of conduct, emotional and hyperkinetic disorders appear most common in this population, and co-morbidity rates are noticeably high (Meltzer et al., 2004). Furthermore, only a small proportion of this at-risk population is likely to be accessing Child and Adolescent Mental Health Services (CAMHS) (Dimigen et al., 1999). Barriers to successful CAMHS input occur at several stages within the process, from identification and referral of mental health problems through to the engagement of the young person and effective interventions for their specific constellation of behaviours and symptoms (Blower et al., 2004; Mount, Lister & Bennun, 2004).

The picture of outcomes of care for these young people is also indicative of health and social services' considerable failure in supporting adequately their mental health and wellbeing. Some examples include higher rates of early pregnancy and lone parenting, lower academic and career success, and greater likelihood of substance misuse (Chambers et al., 2002).

In response to the widely accepted requirement for better mental health services for this group of young people, several recent policies and good practice guidelines have been developed and some core themes have emerged. These include preventative and early intervention models, standardised screening for mental health problems, improved assessment of the presenting problem, steps to engage the young person in a collaborative and non-stigmatising manner, the provision of mental health training for residential practitioners, and very saliently, good multi-agency working (Mount, Lister & Bennun, 2004; Blower et al., 2004; Bunting, 2006; Scott & Hill, 2006; Stanley 2007). In terms of translating the above considerations into a concrete format for service development, *The mental health of children and young people: A framework for prevention, promotion and care* (Scottish Executive, 2004) provides key guidelines and objectives for mental health promotion and care, with specific emphasis on the vulnerability of young people who are living away from home. This document is supported by *Delivering for mental health* (Scottish Executive, 2006), outlining objectives for CAMHS teams including the provision of general mental health training to residential practitioners and the provision of consultation, advice and joint working practices. The Mindful Care pilot project was developed to try and meet some of these needs.

The local context

In the Moray local authority area, there were 120 children and young people looked after away from home on 31st March 2008 in a variety of kinship, foster and residential care placements. Within this, twelve individuals (10 percent) were placed in residential accommodation within Moray. As an area, Moray has no local authority-provided residential provision. All of these children reside in *Action for Children* (AFC) units commissioned by the local authority. This project is a joint initiative between the AFC residential care service in Moray and the associated CAMHS team, targeting this population of children and young people

Methodology

Phase one - Training

The training package consisted of the Young Minds national inter-agency training resource (Catchpole, Goosey & Webb, 2006) and some additional presentations. These presentations consisted of a review of relevant literature, the use and validity of the Strengths and Difficulties Questionnaire (Goodman, 1997) for this population, attachment systems in children in care, and an introduction to Reactive Attachment Disorder. Case studies were designed which reflected the

needs of this group of children, and several informal discussion topics were included specifically geared to the trainees' work environment.

Twenty-six participants took part in this study. Two failed to complete the two-day course due to illness and were omitted from the analysis, giving a total of 24 subjects. The total sample consisted of one residential services manager, two unit managers, two senior project workers and 19 residential child care practitioners. All participants were recruited internally by AFC's residential services manager for Moray, and were written to in advance of the training to inform them of the programme content and arrangements. The effect of the training was measured using a questionnaire of eleven questions designed to measure the ascribed training outcomes of *Mental health of children and young people: A framework for prevention, promotion and care* , as well as learning objectives of the Young Minds national inter-agency training resource. This was administered immediately before, immediately after, and three months following the training course. At the three-month follow-up, 21of the participants returned the final questionnaire, of which 20 did so within the correct timescale and were included in the analysis for the follow-up stage.

Phase two - Introduction of the Strengths and Difficulties Questionnaire(SDQ)

An overview of the SDQ was given during training, specifically concerning its potential use in a new protocol for AFC's residential service supported by the CAMHS team. Following this, an agreement was made between both agencies to hold a trial for a new system. This aimed to obtain a completed SDQ by the referring social worker upon entry into care, from the key worker and young person within two weeks of the placement, an additional joint SDQ made by the 'team view' produced at the in-house residential review meeting, and repeat versions from both the key worker and young person when required, such as to address specific concerns arising from the young person's presentation. It was anticipated that in addition to aiding internal practice in residential units, issues arising from the completion of these questionnaires could be supported through consultation with the CAMHS team.

Phase three – Consultation

A new consultation service was developed and piloted for six months following the completion of the training programme evaluation. This service was specifically for AFC residential care staff, and usually involved the presence of the young person's key worker and unit manager. These individuals could also invite other relevant contributors by mutual agreement, such as social work staff. Each of the three AFC units were offered a monthly consultation session concerning an individual of their choice, with the Consultant Clinical Psychologist who delivered the training, the Systemic Psychotherapist, and if

applicable, any other CAMHS team members who may have the young person on their caseload.

Results

Training Programme

Statistical analysis of the data indicated that there was a statistically significant increase in the subjects' questionnaire scores across the three time points (Pre-training, Post-training and three-month follow-up).This demonstrated that the training was effective in immediately increasing knowledge and confidence levels tested by the questionnaires. Specifically, training created a significant increase in levels of understanding of specific mental health issues and the broader emotional and mental health of children who are looked after away from home, within a developmental context. There was an increased level of confidence in identifying and supporting those with mental health difficulties, in general and also in terms of protective factors. The training also created an increase in perceived ability to obtain specialist support and work collaboratively within the local service system. Additionally, trained staff were more aware of the impact of stress on individuals, the importance of their own contribution to those children they work with, and were more able to address their own emotional needs. At three-month follow-up, there was no significant decrease in the subjects' ratings from levels achieved post-training. It can therefore be concluded that the effect of the training was sustained after three months.

Staff attitudes on the training

The post-training questionnaire included questions to measure how acceptable and relevant the training was to the participants, and also to gauge 'customer satisfaction'. All participants reported the training to have clear objectives, and felt that the trainers facilitated discussion around topics. When asked if the training was relevant to their role, three-quarters of participants stated that this was 'very much' the case, and the remaining quarter felt it was still 'mostly relevant'. In terms of the overall perception of the training, almost all individuals stated that it was either 'good' or 'excellent'.

SDQ and consultation model implementation

Although no quantitative evaluation of these aspects of the Mindful Care pilot project was carried out, two review meetings were held to discuss the progress and outcomes of this phase, at three and six-month time-points. These reviews were attended by the Service Manager from AFC, and Consultant Clinical Psychologist, the Systemic Psychotherapist and the Trainee Clinical Associate Psychologist from the CAMHS team.

With regards to the integration of SDQ use in the new protocol developed by AFC staff, it was felt that this helped to focus practice on particular aspects of the young person's mental health, gave clues as to their individual strengths and areas of potential and had the potency to pick up less obvious difficulties they might be experiencing. It also gave an opportunity for the young person to add in their own feelings and considerations regarding their general mental health and wellbeing, which may provide an easier method than more traditional alternatives. Residential staff also stated that the SDQ held the advantage of not being pathological or negative; focusing on general areas of strengths and difficulties. From the perspective of the CAMHS team, it was thought that the SDQ contributed to good levels of preparation for the consultation sessions, and gave concrete areas to discuss and measure for signs of progress or deterioration. Completed versions from a number of different sources, for example the young person, key worker, unit manager and social worker, also gave important input to systemic considerations concerning particular cases.

The consultation sessions themselves varied considerably in their form and content, ranging from exploring concerns regarding a young person new to the care team, to more systemic discussions concerning a young person with well managed but significant mental health problems. Residential staff reported overall satisfaction with the new service, and valued their own 'space' to use as each team wished. Several individual pieces of work had also been generated by this aspect of the service, including a discreet cognitive functioning assessment of one young person and a priority mental health screening appointment for another.

Discussion

The training of AFC residential staff can be viewed as a success in terms of increasing levels of perceived knowledge of, and confidence in supporting, the mental health and wellbeing of the children and young people in their care. Importantly, the staff felt more able to access specialist support, and work in partnership with other agencies within their local service system. The training proved to be highly rated by the AFC staff to whom it was delivered, demonstrating both a relevance to their role and acceptability of delivery and content. Such collaborative models of training should themselves improve inter-agency working (Hatfield, Harrington & Mohamad, 1996; Barbour et al., 2006; Stanley, 2007).

The introduction of the SDQ and the consultation service were experienced as positive joint service developments, both from perspectives of those working in the residential care service, and for members of the CAMHS team. The consultation model has achieved several positive outcomes which suggest an

improvement to the support of the mental health and wellbeing of children and young people who are looked after away from home in the area, the most important of which is better inter-agency working. While conclusions remain tentative and await further empirical evaluation, there has been a noticeable shift to more appropriate and flexible roles for CAMHS team members in the cases of these children, beyond more traditional individual clinical work, as well as improved practice and communication from residential care team members.

Implications

The inter-agency model of training and consultation discussed here has proven successful for residential practitioners working with challenging young people. It seems likely that a similar training course would also be suitable for other groups caring for and working with this group of young people. In terms of a need for this model of training, a recent report by the Scottish Institute of Residential Child Care (SIRCC) noted that 68 percent of residential staff were unqualified (Lerpiniere et al., 2007). Additionally, many residential staff who are qualified to the level of HNC and SVQ level 3 are potentially untrained in mental health theory or policy relevant to children who are looked after away from home. Training offers a cost-effective option to service delivery and thereby a potential improvement on existing inequalities in the appropriation of limited resources (Hatfield et al., 1996; Minnis et al., 2001). Potential broader implications of training programmes such as this include reducing numbers of placement breakdowns and better learning and social outcomes for this group of children and young people.

Conclusion

This article forms the initial evaluation of the Mindful Care pilot project. There is currently no evidence as to whether the training and supporting consultation model has produced long-lasting changes in clinical practice, and more importantly in outcomes for the mental health and wellbeing of children and young people who are looked after away from home. The initial indications and evaluations reported here are, however, encouraging. Additionally, wider evidence from research supports such directions for inter-agency training and multi-agency working, as well as the development of specialist CAMHS services for children and young people who are looked after away from home. The needs of this population are indisputably great, and moving towards alleviating evident failings in mental health within residential care service provision must progress. It is important that this progression follows empirical pathways, whereby the audit and evaluation of models of good practice and service delivery creates a strong evidence base for future development (McCluskey, 2006). The reality is,

however, that full evaluations of outcomes remain slow and difficult to achieve. Creating mental health services which meet the demands of this population, and a care system which is truly 'mindful' must remain the ultimate priority.

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